# TEXAS SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES


## INTERIM REPORT
## TO THE
## 82ND LEGISLATURE

**December 2010**

*Please direct questions or comments to:*

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

| | |
|---|---|
| Shannon Ghangurde | Committee Director |
| Christina Tippit | Committee Clerk |
| Jordan Head | Policy Analyst |
| Sharen Ludher | Policy Analyst |
| Tara Swayzee | Policy Analyst |

Special thanks to Addie Smith and all of Senator Jane Nelson's staff.

# THE SENATE OF TEXAS
## COMMITTEE ON HEALTH AND HUMAN SERVICES

SAM HOUSTON BLDG.
ROOM 420
P.O. BOX 12068
AUSTIN, TEXAS 78711
(512) 463-0360
FAX: (512) 463-9889
DIAL 711 FOR RELAY CALLS
E-MAIL: jane.nelson@senate.state.tx.us

November 23, 2010



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 assigned with the exception of charge 1, which will be reported on at a later date. The Committee held ten 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 focuses on eliminating waste and inefficiencies in our health and human services system while maintaining our commitment to Texas' most vulnerable citizens. Major issues addressed included obesity prevention, health care quality initiatives, health information technology, workforce shortages, stem cell research, efficiencies in long term care services, abused and neglected children, and state supported living centers.

The Committee has carefully considered all of the testimony received on its charges to provide these recommendations. We appreciate your leadership in asking this Committee to study these key issues and trust that our recommendations will serve to improve health care and human services in Texas.

Respectfully submitted,

Senator Jane Nelson
Chair

Senator Bob Deuell
Vice-Chair

Senator Joan Huffman

Senator Robert Nichols

Senator Dan Patrick

Senator Eliot Shapleigh

Senator Carlos Uresti

Senator Royce West

Senator Judith Zaffirini

## Interim Charges

1. *Federal Health Reform* - Upon passage of federal legislation relating to reform of the health care industry and health insurance industry that the Texas Health and Human Services Commission estimates will costs the State of Texas $2 to 2.5 billion per year in General Revenue beginning as early as 2013, study the implications of such legislation on Texas, the health care industry, and public and private insurance. Study and monitor the implementation of the insurance regulatory changes, changes to high risk pool, and any other insurance mandates. Study the health care policy changes and the impact to the Medicaid and CHIP programs and the state budget. Assess the impact to all uninsured and uncompensated care programs and county programs for the uninsured, including county property tax programs to pay for the uninsured. Make recommendations for the efficient implementation of programs. (Joint charge with Senate Affairs Committee)

2. *Prevention and Early Intervention* - Study the benefits, efficiencies and costs, and effectiveness of the social service related prevention and early intervention programs at the health and human services agencies, the juvenile and adult criminal justice agencies and other government agencies that have programs that address mental illness, substance abuse, child abuse and neglect, domestic violence, single-parent families, absentee fathers, early pregnancy, and unemployment. Study other states' prevention programs and efforts to administer these programs through a merged prevention department. Make recommendations to improve the efficiency and effectiveness of these programs.

3. *HHS Eligibility System* - Review the timeliness and efficiency of the Health and Human Service Commission's eligibility system. Include a review of staffing levels and staffing distribution; implementation of Rider 61; and the increased demand on the system. Make recommendations to improve the efficiency and effectiveness of the system, focusing on policy changes that will not create a large financial burden for the state.

4.*Health Information Exchange* - Study and make recommendations on the state's role for facilitating the exchange of health care information in the future, including using the Medicaid exchange as a framework for the statewide exchange of health information between health care providers to improve quality of care; what information the state would provide; how to use this information to improve care management, prevent medical errors, and reduce unnecessary services; and policies and statutory changes needed to ensure that privacy is protected. Study the feasibility of developing multiple regional health information technology exchanges in Texas.

5. *Health Care Workforce* - Study the state's current and long-range need for physicians, nurses, dentists and other allied health and long-term care professionals. Provide recommendations for ensuring sufficient numbers of health care professionals, focusing on medically underserved and rural areas of the state as well as the border region. Consider health care delivered by Advanced Practice Nurses in terms of access, cost and patient safety and include an assessment of independent prescriptive authority with those states in which prescriptive authority is delegated by a physician. Make recommendations to enhance the efficient use of Advanced Practice Nurses in Texas.

6. *Aging Texans/Guardianship* - Explore strategies to support the needs of aging Texans, including best practices in nursing home diversion, expediting access to community services, and programs to assist seniors and their families in navigating the long-term care system with the goal of helping seniors remain in the community. Study the guardianship program implemented by the Department of Aging and Disabilities and the Department of Adult Protective Services, including the efficiency and effectiveness of the program, the relationship between the two agencies, the appropriate rights for parents, and whether clients and their assets are adequately protected to ensure the state is appropriately indentifying seniors in need of protection.

7. *Obesity and Second-Hand Smoke* - Examine how the state could enact policies to improve the overall health of Texans, focusing on programs that compliment individually-based prevention with community-based prevention to reduce obesity rates by increasing physical activity, improving nutrition, and improving self-management of chronic diseases such as diabetes. Examine obesity-related health disparities between different ethnic groups and ways to narrow these gaps. Consider the fiscal and health impact of second-hand smoke on businesses and service sector employees. Study state-level initiatives to incorporate these individual and community-based prevention strategies, including initiatives pursued in other states.

8. *H1N1 Influenza Pandemic and ImmTrac* - Study the state's ability to appropriately respond to the H1N1 influenza pandemic by examining issues related to vaccine distribution and capacity. Consider the benefit of providing the state's independent school districts and various health authorities with standardized protocols for issues including, but not limited to, vaccine administration, absenteeism and the cancellation of school and other school-related events. Assess the state's ability to track and record H1N1 vaccinations through the ImmTrac registry, and review statutes governing ImmTrac to increase the effectiveness and efficiency of immunization information systems.

9. *Health Care Quality and Efficiency* - Study current state health care quality improvement initiatives in Texas, including statewide health-care associated infection and adverse event reporting, reimbursement reductions in the Texas Medicaid program for preventable adverse events, potentially preventable readmissions identification, health information technology implementation, pay-for-performance programs, and other initiatives aimed at improving the efficiency, safety, and quality of health care in Texas. Identify statutory changes that may build upon efforts to improve quality of care and contain health care costs in Texas. Study policies that encourage and facilitate the use of best practices by health care providers including the best way to report and distribute information on quality of care and the use of best practices to the public and to promote health care provider and payment incentives that will encourage the use of best practices. The study/recommendations could also include assessing the best way to bring provider groups together to increase quality of care, the use of best practices, and reduce unnecessary services.

10. *Texas Medical Board* - Study current practices of the Texas Medical Board relating to the disclosure of complaints.

11. *Stem Cell Data* - Review the types of human stem cell and human cloning research being conducted, funded, or supported by state agencies, including institutions of higher education. Make recommendations for appropriate data collection and funding protocols.

12. *Medicaid Home and Community Based Services Waivers* - Review the Medicaid HCBS waivers (CBA, STAR Plus, CLASS, MDCP, DBMT, TxHmL) and develop recommendations to assure that people with significant disabilities, regardless of disability label or age, receive needed services to remain in or transition to the community. Review should look at the delivery system, eligibility, service packages, rate structures, workforce issues and funding caps. Examine options for the provision of services for children aging out of the Medicaid system. Make recommendations for streamlining/combining these waivers, ensuring that these waivers are cost effective or create cost savings, and developing policies that contain costs in an effort to increase access to the services. The review should examine other states' community care waivers and provide recommendations relating to efforts that have been successful in other states.

13. *CPS Mental Health Services* - Study the type, duration, frequency and effectiveness of mental health services available to and accessed by abused and neglected Texas children. Recommend strategies to address the impact of the trauma, and enhance therapeutic services available to this population in an effort to eliminate the cycle of abuse and neglect.

14. Monitor the implementation of legislation addressed by the Senate Committee on Health & Human Services, 81st Legislature, Regular and Called Sessions, and make recommendations for any legislation needed to improve, enhance, and/or complete implementation.

- *Fostering Connections Act* - Monitor Department of Family and Protective Services' implementation of the U.S. Fostering Connections Act, including the new Kinship Care program. Include recommendations on how to optimize the use of monetary assistance to qualified relative caregivers.
- *State Supported Living Centers* - Monitor the Department of Aging and Disability Services(DADS) implementation of SB 643, relating to Texas' state supported living centers (SSLCs), implementation of Special Provisions relating to All Health and Human Services Agencies, Section 48. Contingency Appropriation for the Reshaping of the System for Providing Services to Individuals with Developmental Disabilities, and implementation of the United States Department of Justice (DOJ) Settlement Agreement terms.

# TABLE OF CONTENTS

Interim Charge #2: *Study the benefits, efficiencies, costs, and effectiveness of the social service related prevention and early intervention programs at the health and human services agencies, the juvenile and adult criminal justice agencies, and other government agencies that have programs that address mental illness, substance abuse, child abuse and neglect, domestic violence, single-parent families, absentee fathers, early pregnancy, and unemployment. Study other states' prevention programs and efforts to administer these programs through a merged prevention department. Make recommendations to improve the efficiency and effectiveness of these programs.*

# Section I: Background

## Overview of Prevention and Early Intervention in Texas

Texas Prevention and Early Intervention (PEI) programs are administered by several state agencies and seek to minimize child abuse and neglect, substance abuse, unemployment, teen pregnancy, and domestic violence, among others. These issues are closely related and typically not independent of each other.[1]

A single client of PEI services may be served through programs at different agencies through multiple access points. For example, a family could receive child abuse prevention services through the Department of Family and Protective Services (DFPS); substance abuse treatment through Texas Youth Commission (TYC); mental health services through the Department of State Health Services (DSHS); and job assistance training through Texas Workforce Commission (TWC). Overlap of PEI services often necessitate collaboration between agencies and program administrators to ensure that services are not duplicated and that the process of moving between programs is as seamless as possible.

Furthermore, the state's evaluation of PEI programs' effectiveness varies not only across agencies, but also within individual agencies themselves. Consistent evaluation measures across all PEI programs are necessary in order to accurately assess the effectiveness of Texas's delivery of PEI services.

Texas agencies with the most substantial prevention programs are listed below. See the appendix for a detailed list of each agency's PEI programs.

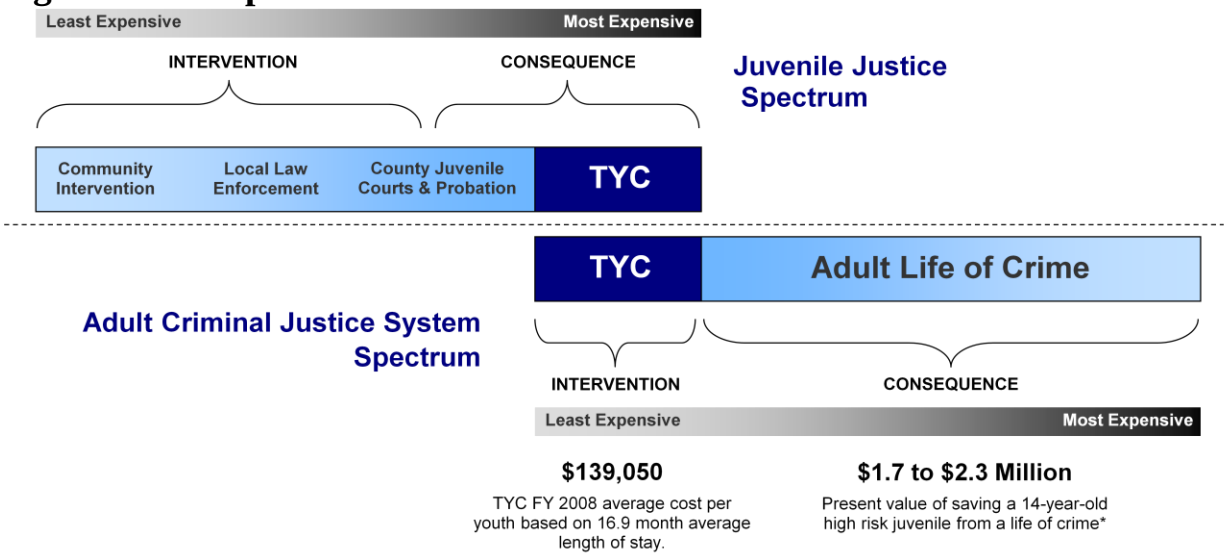
- ***Department of Family and Protective Services (DFPS)***: primarily focuses on the prevention of child abuse and neglect. DFPS also attempts to prevent secondary issues related to the cycle of abuse and neglect, such as mental illness, substance abuse, domestic violence, and early pregnancy. The agency's programs range from juvenile delinquency prevention to more focused programs that specifically aim to prevent victims of child abuse from engaging in self-destructive or reckless behavior (e.g., experimenting with drugs, unintended pregnancies).
- ***Department of State Health Services (DSHS)***: primarily focuses on the prevention of suicide, substance abuse (alcohol, tobacco, and drugs), unintended pregnancy, and child abuse and neglect.
- ***Office of the Attorney General (OAG)***: primarily focuses on identifying and removing barriers to providing consistent financial, emotional, and social child support; preventing unplanned teen pregnancy; and providing resources to support healthy co-parenting relationships.

- ***Texas Education Agency (TEA)***: primarily focuses on the promotion of health education, community support of education, college and workforce readiness, dropout prevention, family support and parental involvement. TEA's programs also support vulnerable populations within Texas schools (e.g., mentoring children with a parent who is incarcerated, providing free prekindergarten services for eligible children, providing support services to middle and high school children with intellectual disabilities).
- ***Texas Workforce Commission (TWC)***: primarily focuses on prevention of unemployment. Services available to individual workers and families include job search assistance and access to training, transportation, child care, and unemployment benefits.
- ***Texas Youth Commission (TYC)***: primarily focuses on youth who have already experienced or engaged in problem behaviors in an effort to reduce recidivism.

## Section II: Analysis

The benefit of prevention lies in its ability to identify a potential problem before it occurs and set an at-risk individual on a positive trajectory. State investments in prevention programs are typically less costly than interventions once a problem has already occurred.[2] Many of the issues PEI programs strive to prevent or mitigate occur across a spectrum – as the problem worsens, intervention becomes more expensive. The cost of PEI programs varies depending on the point along the spectrum at which the recipient accesses services. Some advocate for focusing resources on primary prevention activities occurring at the beginning of the spectrum. These interventions aim to raise awareness about a problem among the general public in an attempt to stop negative behavior before it starts. Others argue that funding should be shifted to interventions – secondary prevention programs focused on groups who are deemed to be especially at-risk, and tertiary prevention activities that aim to prevent a reoccurrence or exacerbation of a problem that has already occurred.[3] For example, Figure 1 illustrates the types and costs of programs that aim to prevent juvenile delinquency and a subsequent life of crime.

### Figure 1. PEI Spectrum at TYC[4]



## PEI Program Effectiveness

As stewards of taxpayer dollars, the Legislature must ensure that all resources allocated for prevention provide positive results. Currently, the effectiveness of PEI programs is measured in two ways:

- *Output Measures*: All agencies, in coordination with the Legislative Budget Board (LBB) and Governor, develop numerical targets, or output measures, that each program must meet each fiscal year. These numerical targets are included in agencies' Legislative Appropriations Requests.[5] For PEI programs, output measures are largely based on the program's budget from the preceding biennium and the projected average cost per recipient served. A common example of an output measure is the average number of families served by a given PEI program in a fiscal year.
- *Outcome Measures*: Outcome measures are developed internally by each agency, and there is no mandated procedure for how they are developed. Most commonly, outcome measures can be categorized as internal or external reviews. Internal performance tracking is performed within the agency by staff through audits, reviews, surveys, and reports. External reviews are usually performed by independent groups, such as universities. For example, the Criminal Justice Policy Council provided an external review of the Community Youth Development program at DFPS, and the University of Houston provided an external review of the CPS' abuse and neglect programs' effectiveness and cost efficiency.[6]

Agencies that contract with service providers use the LBB output measures as well as the agencies' internal outcome measures to develop performance measures for these contractors.[7]

***Output Numbers Are Not Always the Best Effectiveness Measurements***

The number of clients that move through the PEI system is not always the best indicator of quality. Output measures simply tally the number of projected recipients for PEI program services after assessing a per-client cost for services.[8] Output numbers do not usually take into account the agencies' outcome measures, resulting in an isolated numerical measurement based almost entirely on the cost of services.

Although agencies that utilize contracted service providers measure contract performance using both output and outcome measures, some contractors report that significantly more emphasis is placed on the output measures, rather than on outcome measures, and that contractors are forced to sacrifice providing impactful, long-lasting prevention services to recipients of PEI services in favor of processing enough recipients through the system to meet contract output requirements.[9]

Contract service providers also report that they have little, if any, input regarding how their contract performance measures are determined. A reevaluation of LBB output measures, how they are developed, how useful they are in measuring the actual performance of programs, and how they are used to determine contract performance measures may be valuable.

***Inconsistent Measurements***
Recipients of PEI services often seek services from several PEI programs. Currently, there is no mechanism in place to evaluate how the PEI system in its entirety is helping recipients improve outcomes as a whole because program effectiveness measures are usually not consistent across agencies. Ideally, standardized performance measures could apply to all PEI programs across agencies to measure the effectiveness of the PEI system as a whole. However, different programs serve different purposes and the measurement tools they use must reflect those differences.

Prior to the 2013 legislative session, the Texas Sunset Advisory Commission will review and make recommendations regarding the operations of agencies under the purview of the Health and Human Services Commission (HHSC). The Sunset Advisory Commission should analyze the different performance measures used to evaluate the effectiveness of PEI programs across HHSC agencies and make recommendations for how to streamline these measurements. Although this would exclude non-HHSC agencies such as TYC, it would provide a foundation to create a streamlined approach to evaluating the effectiveness of PEI services as a whole.

***Long-term Outcomes***
Current outcome measures typically look at how clients perform while still enrolled in a PEI program. Evaluation tools are not designed to measure long-term outcomes of clients after they are no longer receiving PEI services. This is typically because state agencies and contract service providers lose the ability to track the progress of recipients of PEI services after they have completed PEI programs and recipients have no duty or requirement to report back to the respective agencies through surveys, follow-up questions, or otherwise. Additionally, in some cases, the agency that administers the PEI program loses jurisdiction over the client. For example, after a child housed under the authority of TYC has left the agency's custody, the agency no longer has jurisdiction to follow-up on the child's progress.[10] It is difficult and resource-intensive to attempt to track down former clients who may have moved across counties and even across state lines. Consideration of a mechanism by which agencies could ensure follow-up evaluation of PEI service recipients after their completion of PEI programs may assist in assessing a more realistic measure of PEI program effectiveness.

## Coordination of Prevention Activities Across Agencies
Recipients of PEI services are often served by programs across agencies. It is important that these programs communicate in a collaborative way that allows services to be provided as seamlessly as possible. Agencies currently coordinate services through Memoranda of Understanding (MOU) between agencies, taskforces, and interagency councils.

- *MOU between Agencies*: often include sharing of records and information; coordinating services for recipients by facilitating communication between caseworkers at different agencies; and committing to share data on evaluation of programs and performance measures.
- *Task Forces and Interagency Councils*: conduct inventories of programs within individual agencies to identify duplicative programs and opportunities for collaboration; create strategic plans for programs across agencies.

***Barriers to Cross-Agency Coordination***

There are a variety of barriers to cross-agency coordination of PEI programs, which include legal, technological, and federal funding issues.

*Legal*

Federal confidentiality laws severely limit the extent to which agencies can share data on recipients of PEI services.[11] For example, DFPS is prohibited from disclosing client information under federal law.[12] Data sharing is further complicated by laws that limit the sharing of health-related information, such as the Health Insurance Portability and Accountability Act (HIPAA). Many of the records that agencies maintain on PEI clients contain information on past and current medical conditions and treatments, which are strictly prohibited from being shared or disclosed. Federal and state statute should be carefully reviewed to determine if Texas can apply for a waiver to allow for more data sharing between agencies.

*Technology*

State agencies have different software for databases and data sharing. Streamlining these systems would be costly, time-intensive, and would require staff to be re-trained.[13] However, the state should work to identify any technological advances or developments that could be made to allow different systems to communicate across agencies.

*Federal Funding*

PEI programs in Texas are supported in large part by federal funding. Each federally-funded program has a specific set of reporting requirements with which its award recipients must comply. Therefore, if state agencies secure funding from multiple federal sources, they must meet multiple reporting requirements that vary in terms of format, substance, and reporting frequency.

Agencies receiving federal funding are typically required to dedicate those funds to specific programs and services, and must demonstrate that the funding accomplished the specific goals of the federal program.[14] For example, federal funding for child support programs are limited to federally predetermined purposes, such as locating absent parents, establishing paternity, and enforcing child support.[15] In order to spend those funds on PEI, the programs must in some way be linked to one of those goals.[16] The OAG's Parenting and Paternity Awareness (p.a.p.a.) program, which educates students on the legal, financial, and emotional realties of being a parent and the value of postponing parenthood, is linked back to the federally predetermined purpose of establishing paternity.

## Evaluation of Merged Prevention

Some advocates suggest that the best way to coordinate PEI efforts across Texas and maximize their benefits is to merge all prevention programs into one agency or department. Under this system, consumers would access all prevention services through one access point and work with only one caseworker. Streamlining services could minimize duplication and improve the state's ability to evaluate prevention effectiveness.

Although merging prevention programs into one department offers potential improvements to the system, the practical implications present significant barriers. Prevention programs are often embedded into an agency's statutory responsibilities. For example, DFPS focuses on the prevention of or intervention in child abuse and neglect. Prevention services occur throughout the state's involvement with a family, including before a child is removed from the home, while the child has been temporarily placed in foster care or even after rights of a parent have been terminated. Services are available to all individuals impacted by the abuse, including an abusing parent, relatives with whom a child is placed, foster parents or an abused child. In this instance, shifting prevention services into a separate agency could potentially further fragment the state's efforts to combat abuse and neglect. Alternatively, if the entire operations of DFPS were transferred to the prevention department, the department would evolve into an unmanageable agency.

Each agency has the expertise to deal with a specific subject area and clientele. Merging prevention into a single department would impact the expertise and continuity of care offered by agencies. Furthermore, many prevention programs operate through contracts with community-based services providers. Moving these programs to another agency would require all contracts to be re-procured, resulting in a lapse in services for many individuals and families. Associated changes in contract managers would also be disruptive to the continuity of services.

Washington has attempted to streamline services by creating the Department of Social and Health Services to provide access to a variety of services ranging from food stamps and Medicaid to child abuse prevention and substance abuse treatment programs.[17] However, this merged department focuses on health and social services, not solely on prevention. For a more detailed review, Senate Bill 2080 (Uresti/Nelson/Patrick 81R) set up a Blue Ribbon Task Force that is currently researching state practices and strategic plans for merged prevention in Florida, North Carolina, Washington, New Jersey, and Wisconsin. The Task Force's report is due in August 2011. [18]

## Looking Forward

All state agencies in Texas are required by the Governor and the LBB to create and implement five-year Strategic Plans describing each agency's mission and goals, output and outcome measures, use of resources, and means and strategies for achieving the agency goals.[19] Although language about an agency's PEI programs may be included in the broad goals of the agency, there is no specific requirement that agencies set goals, objectives, and outcome targets for their PEI programs. Adding a PEI-specific element to each relevant agency's Strategic Plan would ensure that moving forward, agencies see PEI as a primary function of the agency.

The recent federal health care reform legislation required each state to complete a State Needs Assessments[20]. This assessment must identify communities with concentrations of premature births, low birth-weight infants, infant mortality, poverty, crime, domestic violence, high rates of high school drop-outs, substance abuse, and unemployment. The assessment must also evaluate the quality and capacity of existing early childhood programs or initiatives, and discuss the state's capacity for providing services to these at-risk populations.[21] The Texas State Needs Assessment, which was recently completed by DSHS, identifies the incidence of these problems

by health service region (there are 11 in Texas) and forms a big picture of the extent of these problems throughout the state and where particular problems are more pronounced.[22] The results of this assessment should be used by agencies in their strategic plan and in other planning endeavors to focus PEI services in areas of the state where there is the greatest need.

## Section III: Conclusion

The key to efficient delivery of PEI services is streamlining coordination of efforts between agencies. Additionally, funding of PEI programs should be based on performance measures of effectiveness to ensure that successful PEI programs that are producing positive outcomes are sustained. Moving forward, the state may be able to maximize PEI efficiency and effectiveness by targeting areas of the state with the greatest need for these services as identified by the State Needs Assessment.

## Section IV: Recommendations

1. **Texas Sunset Commission should review the program evaluation mechanisms used to measure outcomes in Prevention and Early Intervention programs across state agencies.**

2. **Include Prevention and Early Intervention in relevant agencies' Strategic Plans.**

3. **Encourage agencies to use the Texas State Needs Assessment to determine the areas of the state with the greatest levels of need for Prevention and Early Intervention services.**

---

[1] McClure, Madeline, TexProtects, *Testimony before the Senate Committee on Health and Human Services*, 2, (Austin, TX, April 15, 2010).
[2] Saxton, Josette, Texans Care for Children, *Testimony before the Senate Committee on Health and Human Services*, 4, (Austin, TX, April 15, 2010).
[3] McClure, *supra* note 1, at 32.
[4] Cohen, Mark A., and Alex R. Piquero, *New Evidence on the Monetary Value of Saving a High Risk Youth*, December 2007 [Journal of Quantitative Criminology; Volume 25, Number 1 / March, 2009].
[5] These measures are used for all agency programs, not just PEI programs.
[6] Deckinga, Audrey, Department of Family Protective Services, *Testimony before the Senate Committee on Health and Human Services*, 5, (Austin, TX, April 15, 2010).
[7] *Id.* at 4.
[8] Department of Family Protective Services, Legislative Appropriations Request, 2012-13 Biennium, 2010, 48.
[9] Crowe, Julie, DePelchin Children's Center Hearing Presentation, *Testimony before the Senate Committee on Health and Human Services*, 3, (Austin, TX, April 15, 2010).
[10] Townsend, Cheryln K., Texas Youth Commission, *Testimony before the Senate Committee on Health and Human Services*, 14, (Austin, TX, April 15, 2010).
[11] Deckinga, *supra* note 6, at 11.
[12] Section 106 of the Child Abuse Prevention and Treatment Act (CAPTA) and Section 471 of Title IV-E of the Social Security Act.
[13] Townsend, *supra* note 10.

[14] Whiteside, David, Texas Department of Family and Protective Services, " Requested Information," email to the author, November 15, 2010.
[15] Key, Alicia, Offices of the Attorney General, *Testimony before the Senate Committee on Health and Human Services*, 4, (Austin, TX, April 15, 2010).
[16] *Id.*
[17] Washington State Department of Social and Health Services, Available: http://www.dshs.wa.gov/, Accessed: November 9, 2010.
[18] McClure, *supra* note 1, at 3.
[19] *Id.*
[20] Patient Protection and Affordable Care Act, Section 511 to Title V of the Social Security Act for Maternal, Infant, and Early Childhood Home Visiting programs.
[21] Nurse-Family Partnership, *Public Policy Update: HHS Releases Statewide Needs Assessment Information*, 1, August 24, 2010.
[22] Texas Department of State Health Services, Division of Family and Community Health Services, "Texas Home Visiting Needs assessment for the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program," September 20, 2010.

# Appendix

| Department of Family and Protective Services | | | |
|---|---|---|---|
| **Program Name** | **Description** | **Target Population** | **Approximate Number Served Annually** |
| Community Youth Development | Community-based organizations develop juvenile delinquency prevention programs. Approaches used by communities to prevent delinquency have included mentoring, leadership development, youth employment programs, career preparation, academic support and alternative recreational activities. Communities prioritize and fund specific prevention services according to local needs. | Youth up to age 17 who reside in, or attend school in, one of the 15 targeted ZIP codes (based on high juvenile crime rates) are eligible to receive services. | 19,390 |
| Statewide Youth Service Network | Community and evidence-based juvenile delinquency prevention programs | Services are focused on youth ages 10 through 17, and are available in each DFPS region. | 6,548 |
| Youth Resiliency | Services proven to increase protective factors for youth. A variety of services are available across the state designed to increase youth resiliency and prevent juvenile delinquency. These programs must foster strong community collaboration to provide a continuum of services for participating youth. | Youth up to age 17 who exhibit two or more of a defined set of risk factors are eligible for services, with the focus on youth ages 10 through 17. | 1,654 |
| Services to At-Risk Youth | Services include family crisis intervention counseling, short-term emergency respite care, and individual and family counseling. Each STAR contractor also provides universal child abuse prevention services, ranging from local media campaigns to informational brochures and parenting classes. | Youth up to age 17 and their families are eligible if they experience conflict at home, are truant or delinquent, or run away from home. STAR services are available in all 254 Texas counties. | 29,406 |
| Texas Families: Together and Safe | Evidence-based, community-based programs designed to alleviate stress and promote parental competencies and behaviors that increase the ability of families to become self-sufficient and successfully nurture their children. | Families with at least one primary caregiver and one child 0-17, or expecting a child, are eligible to receive services. | 3,040 |

| Program Name | Description | Target Population | Approximate Number Served Annually |
|---|---|---|---|
| Family Strengthening | Services have been evaluated and proven to effectively increase family protective factors. These services are designed to increase the resiliency of families and prevent child abuse and neglect. Programs must also foster strong community collaboration to provide a continuum of family services. | Families including at least one primary caregiver and one child up to 17 years of age, who exhibit two or more of a defined set of risk factors, or those referred by CPS, are eligible for services. | 1,200 |
| Community Based Child Abuse Prevention | The program seeks to increase community awareness of existing prevention services, strengthen community and parental involvement in child abuse prevention efforts, and encourage families to engage in services that are already available. Evidence-based services including parent education and case management services are utilized. | Families including at least one primary caregiver and one child up to 17 years of age are eligible for services. | 180 |
| Tertiary Prevention Services | Community-based, volunteer-driven prevention, intervention, and aftercare services are provided for children who are or have been, or who are at risk of being, abused and/or neglected. The goals of the program include reducing child maltreatment and the number of families re-entering the Child Protective Services system. Additional goals are to improve the quality and availability of aftercare services for abused children and enhance a statewide network of tertiary child abuse prevention programs. | Serves families with a closed CPS case, where CPS has determined that the family has controlled risk factors and will likely benefit from receiving community-based after-care services. | 32 |
| Community Based Family Services | Community- and evidence-based services include home visitation, case management, and additional social services to provide a safe and stable home environment. | Serves families referred by CPS in whose cases the allegations were unsubstantiated. | 110 |

| Program Name | Description | Target Population | Approximate Number Served Annually |
|---|---|---|---|
| Texas Youth and Runaway Hotlines | The toll-free Texas Runaway Hotline and the Texas Youth Hotline offer crisis intervention, telephone counseling, and referrals to troubled youth and families. Volunteers answer the phones and interact with callers facing a variety of problems including family conflict, delinquency, truancy, and abuse and neglect issues. The program increases public awareness through media efforts that may include television, radio, billboards and other printed materials. | Texas youth and families, school counselors, and others involved with youth utilize the Hotlines services. | 13,072 |
| **Department of State Health Services** | | | |
| **Program Name** | **Description** | **Target Population** | **Number Served Annually** |
| Child Fatality Review Teams (CFRTs) [Child Abuse and Neglect] | Develops local child maltreatment education initiatives for parents, daycare providers, schools, and the community at large. The initiatives will inform them on child abuse and neglect, the responsibility to report, and resources for families at risk. | The initiatives are accessible to all parents, grandparents, educators, and all members of the community. | Not tracked by the local Child Fatality Review Teams |
| Child Fatality Review Teams (CFRTs) [Injury] | A wide variety of injury prevention initiatives are done by local teams depending on the data-driven issues in their community: child passenger safety seat inspection clinics, community education on safe sleep for infants, community education on the dangers of distracted driving, water safety, education on suicide prevention, bicycle safety, etc. | The injury prevention initiatives are intended to serve those who have children, who care for children, and who serve children. | Data not collected |

| Program Name | Description | Target Population | Approximate Number Served Annually |
|---|---|---|---|
| MEDCARES (Medical Child Abuse Resource and Education System) Grant Program (Senate Bill 2080) | The program's intent is to award grants in support of regional hospitals and academic health care centers with an expertise in pediatric health care that are committed to improving the assessment, diagnosis, and treatment of child abuse/neglect. The focus of the use of grant funds disseminated through MEDCARES is not prevention/ intervention. The MEDCARES Advisory Committee members were appointed based on the criteria laid out in the SB2080. They represent experts in various health-related fields within the HHS enterprise as well as external agencies. Per the bill, members collaborate to advise DSHS and the Executive Commissioner in establishing rules and priorities for the use of grant funds awarded through MEDCARES and assist with subsequent reports to the Governor's office. No barriers have been identified at this point. | The MEDCARES grant program was established to award grants only. Grants will be awarded to qualifying hospitals and academic health care centers. | None. MEDCARES itself is not intended to serve clients. |
| Family Planning | Offer preventive health services, including medical exams, laboratory tests, provision of contraceptive methods, counseling, and education, to reduce unintended pregnancies, improve health status, and positively affect future pregnancies. The program works with HHSC regarding Womens' Health Program (WHP) and traditional Medicaid for Family Planning. | Low-income females of childbearing age and males who have not had sterilization surgery or other condition resulting in sterilization and who are seeking family planning services. | 196,244 |

| Program Name | Description | Target Population | Approximate Number Served Annually |
|---|---|---|---|
| Substance Abuse Prevention | Prevent the onset of the use of alcohol, tobacco, and other drugs (ATOD) by youth as well as the onset of related mental health disorders through a comprehensive framework that includes evidence based programs and ATOD-free activities. The focus is on the prevention of substance abuse and related mental health disorders to meet the needs of individuals, families, and communities. These programs foster the development of positive social and physical environments that facilitate healthy, drug-free lifestyles by enhancing protective factors and decreasing risk factors. | Youth, ages 0-17 as the primary population and their parents or guardians as the secondary population. | 169,387 |
| Tobacco Prevention and Control--Tobacco Cessation Services | The Quitline is a free and confidential telephone tobacco cessation counseling service. Nicotine replacement therapy is provided to callers as indicated. Well-trained telephone counselors provide professional support that can double a caller's chance of successfully quitting smoking. Self-help materials, information for third party callers including physicians, and local referrals are available to callers. | Texas tobacco users and their families. | 6,007 |
| Tobacco Prevention and Control Coalition (TPCC) Program | Six community coalitions are funded to provide comprehensive tobacco prevention and control strategies to prevent and reduce tobacco use in 15 counties across the state. The coalitions assess the community's needs for tobacco prevention and control; build capacity and partnerships to address these needs; and plan, implement, and evaluate proven programs designed to address tobacco use among adults and youth. Coalition funding is provided through the City of Austin Health and Human Services Department, Ector County Health Department, Fort Bend County Health and Human Services Department, Lubbock-Cooper Independent School District, Northeast Texas Public Health District, and the San Antonio Metropolitan Health District. | General population in the TPCC target area. | 3,350,975 |

| Program Name | Description | Target Population | Approximate Number Served Annually |
|---|---|---|---|
| Prevention and Preparedness, Family and Community Health, Mental Health, and Substance Abuse | The ESC Project is a collaborative effort with Coordinated School Health that advances an evidence based, holistic approach to children's physical and behavioral health and assists the Education Service Centers (ESCs) in being successful in improving learning and academic achievement. Texas schools are supported by 20 regional ESCs. Utilization of the School Health Specialist within the 20 regional ESCs allowed the DSHS ESC Project to provide a blueprint for similar program coordination initiatives across the agency. One key component of the collaboration is the provision of Gatekeeper Training provided to school personnel as well as community members in an attempt to decrease suicide among young Texans. | School administrators, school boards, PTAs, and teachers. | 1,778 |
| Mental Health & Substance Abuse, Child & Adolescent Services | The Texas Youth Suicide Prevention Project (TYSP) provides suicide prevention and early intervention activities targeting youth at higher risk of suicide. DSHS contracted with Mental Health America of Texas (MHAT) in Austin to provide statewide public awareness, capacity building, education, and training. DSHS contracted with the Center for Health Care Services (CHCS) in San Antonio to screen youths at Brooke Army Medical Center Child and Adolescent Pediatric Clinic and Fort Sam Houston Independent School District. Youths that screen positive (at-risk) were referred to outpatient and inpatient settings in the San Antonio area. Redstone Analytics is the third contractor who was responsible for all SAMHSA-required deliverables for data management. | MHAT's activities targeted individuals who identify and refer youth at higher risk of suicide (gatekeeper training) and the public (web sites, media releases, brochures, toolkit). | CHCS screened 283 youths at the Brooke Army Medical Center Child and Adolescent Pediatric Clinic and the Fort Sam Houston Independent School District. Of the 283 screened, 90 were referred to inpatient or outpatient settings in the San Antonio area. |

| Office of the Attorney General | | | |
|---|---|---|---|
| **Program Name** | **Description** | **Target Population** | **Number Served Annually** |
| p.a.p.a. | p.a.p.a. is the curriculum developed by the OAG and being used in all public high school and middle school health classes. It educates students on the legal, financial, and emotional realities of being a parent. While not a traditional pregnancy prevention program, p.a.p.a. has a strong emphasis on the value of postponing parenthood until after students have completed their education, entered a career, and are in a stable, committed (preferably marital) relationship – or in other words, the *why* of prevention. | Middle and High School Students. | 300,000 |
| No Kidding | A peer education model of the p.a.p.a. curriculum. Young parents (No Kidding Interns) are trained by child support staff and community based youth development professionals to present an abbreviated p.a.p.a. curriculum to middle school and high school students. The real life stories of the young parents amplify the curriculum messages and drive home the realities and challenges of being a teen parent. | Middle and High School Students. | 15,000 |
| Shared Parenting Program | The Shared Parenting program helps noncustodial parents increase parenting time and emotional engagement with their children through grants to local access and visitation service providers (12 grantees plus the Access and Visitation Hotline), public education materials (My Sticker Calendar, For Our Children Co-Parenting Guide and video), and direct services in the form of Parenting Order Legal Clinics. | Separated, divorced, or unmarried parents and grandparent caregivers - priority focus on unmarried parents in the Title IV-D Child Support system. | 28,000 through local providers, parenting education materials to 50,000 parents, legal clinics serve 1,500 parents |
| Father Involvement Education | The Child Support Division provides educational materials to noncustodial parents and trains other agency staff (e.g. Texas Nurse Family Partnership, Early Head Start, Healthy Start) on strategies to involve fathers. Materials include: Maps for New Dads (A Prenatal Father Involvement Handbook), Parenting Two-Gether, For Our Children: Learning to Work Together Co-Parenting Guide and DVD, and Father Involvement Posters. | Training and education resources provided to noncustodial parents, Texas Nurse Family Partnership Staff, Early Head Start, and Healthy Start staff. | Training provided to 400 staff and resources distributed to 7,000–10,000 parents |

| Program Name | Description | Target Population | Number Served Annually |
|---|---|---|---|
| Safe Access to Child Support | The OAG is working closely with the Texas Council on Family Violence and local family violence programs on this new project to develop public education materials, child support staff training, and family violence program staff training resources to increase access to safe, consistent financial support for survivors of family violence. | Survivors of family violence who either currently have a child support case or who may need child support. In addition, survivors of family violence with perpetrators who try to use the family law system to continue to exert power and control over the survivor. | 140,000 |
| Prenatal Paternity Education | The Child Support Division works with prenatal providers (Women, Infants and Children (WIC) program, Maternal Child Health programs, Nurse Family Partnership, etc.) and community based parenting programs to provide information to expectant or new parents on paternity establishment, legal responsibilities, and the value of both parents being cooperatively involved in a child's life. Training includes strategies and skills for engaging fathers in program services. | Training and education resources provided to local prenatal providers, Texas Nurse Family Partnership staff, WIC program staff, Life Skills for Pregnant and Parenting Teens staff, community-based parent education program staff - end target audience is unmarried expectant mothers and their partners. | 500 |
| Other Victim Assistance Grants (OVAG) | Grants that support services that address unmet needs of victims of crime, including direct victim services; outreach or community education; connecting crime victims to services to aid in their recovery; and training for professionals and volunteers to improve services to victims. | Recipients are governmental entities or nonprofit organizations that provide victim-related services. | 211 grants to serve 102,922 victims of crime |
| Victim Coordinator and Liaison Grants (VCLG) | Grants that support statutorily required Victim Assistance Coordinator and Crime Victim Liaison positions for local law enforcement agencies and prosecutor offices. The positions funded by these programs provide direct services to victims of crime, including assisting them with crime victims' compensation applications and statutory rights. | Recipients are local law enforcement agencies and prosecutor offices. | 76 VCLG grants to serve 35,696 victims of crime |
| Sexual Assault Prevention and Crisis Services Program (SAPCS) | Contracts to conduct sexual assault primary prevention activities; contracts to statewide organizations to provide training and technical assistance to local sexual assault programs, other local statewide organizations, and to support a statewide public awareness campaign; and contracts for sexual assault nurse examiner training services. | Recipients are local and statewide sexual assault programs, and sexual assault nurse examiners. | 226 SAPCS contracts to serve 21,208 survivors from 236 counties. |

| Program Name | Description | Target Population | Number Served Annually |
|---|---|---|---|
| Statewide Automated Victim Notification System (Texas VINE) | Contracts that support a notification service that provides victims and concerned members of the community with up-to-date information about offenders' county and state jail custody and court status. Registered users are contacted by phone or e-mail whenever there is a change in the offender's status. This information is provided through a single statewide toll-free telephone number and website. The OAG contracts with Appriss, Inc. to work directly with TDCJ and 164 Texas counties who participate in the program. | Recipients are Texas counties and Texas Department of Criminal Justice. | 168 Texas contracts to cover 95% of the state's population and 97% of the reported violent crime |
| Court Appointed Special Advocates (CASA) | The grant program's purpose is to develop and support local CASA programs throughout Texas. CASA programs recruit, train and provide court-appointed volunteers to advocate on behalf of the best interests of abused and neglected children involved in the legal and welfare systems. | The Texas Legislature directs the OAG to contract with a statewide organization that has expertise in the dynamics of child abuse and neglect as well as experience in operating volunteer advocate programs that provide training, technical assistance, and evaluation services. The designated funds are awarded to Texas CASA, Inc., the statewide organization, which subcontracts with local programs to provide victim-related services. Eligible local CASA programs must use volunteers appointed by the court to provide for the needs of abused or neglected children; provide services that encourage permanent placement for abused and neglected children; and provide court-appointed advocacy services to at least ten children each month. | 1 contract to Texas CASA, Inc. Texas CASA Inc. subcontracted to 66 local CASA programs. Local CASA programs provided services to 19,818 children in 204 counties. |

| Program Name | Description | Target Population | Number Served Annually |
|---|---|---|---|
| Children's Advocacy Centers (CAC) | The Legislature directs the OAG to award funds to a statewide organization that has expertise in the establishment and operation of local children's advocacy center programs. The funds are awarded to Children's Advocacy Centers of Texas, Inc. (CACTX), which subcontracts with local CAC programs to provide victim-related services. | The Legislature directs the OAG to award funds to a statewide organization that has expertise in the establishment and operation of local children's advocacy center programs. The funds are awarded to CACTX, which subcontracts with local CAC programs to provide victim-related services. | 1 contract to CACTX. CACTX subcontracted to 64 local CAC programs, that provided services to 32,683 children. Full services were provided in 151 counties, limited services in an additional 96 counties, 41 other states, and 3 other countries. |
| Crime Victim Civil Legal Services Grants (CVCLS) | Grants authorized by the Legislature to increase the availability of free or affordable civil legal services for victims of crime, such as protective orders, disability benefits and other legal assistance. | The OAG entered into an interagency contract with the Supreme Court of Texas (Court) to support the Crime Victim Civil Legal Services Grants. The Court contracts with the Texas Access to Justice Foundation (TAJF) to award and manage these grant funds. | 1 contract to the Supreme Court of Texas. The Court subcontracted $2,447,500 to 24 local crime victim civil legal services programs. Local and statewide programs served 19,301 victims of crime in 200 counties. |
| Sexual Assault Services Program Grant | Grant required by the Texas Legislature to be awarded to a statewide organization that has expertise in understanding the dynamics of sexual assault, developing informational materials, and providing training for sexual assault programs and community professional groups. These funds have been awarded to the Texas Association Against Sexual Assault (TAASA) which supports sexual assault crisis intervention and prevention programs throughout the state. | These funds have been awarded to TAASA for the Sexual Assault Program Grant activities throughout the state. | 1 contract to TAASA |
| **Texas Education Agency** | | | |
| **Program Name** | **Description** | **Target Population** | **Number Served Annually** |
| Amachi | The grant provides mentoring services to students in school, providing mentors to children who have a parent who is incarcerated. | Children who have a parent who is incarcerated. | Data not available |

| Program Name | Description | Target Population | Number Served Annually |
|---|---|---|---|
| Health Education Youth Risky Behavior Survey | The contract with DSHS funds the Youth Risky Behavior Survey. | TEA, DSHS programs, university researchers, local health departments, regional education service centers, local school district personnel, and other interested parties. | 30 |
| Pre-K Early Start | This program serves students who are eligible for free prekindergarten services. This includes 3- and 4-year olds who are currently or have previously been in the conservatorship of DFPS following an adversary hearing. | At-risk 3- and 4-year-old students eligible for free pre-k per TEC § 29.153, Free Pre-kindergarten for Certain Children. | 200,529 enrolled (191,750 were eligible for free pre-k) |
| Best Buddies | This grant in designed to enhance the lives of middle school and high school children in Texas with intellectual disabilities by providing opportunities for one-to-one friendships and integrated employment. | Middle and high school students with intellectual disabilities. | 30 high school chapters; 390 students with disabilities |
| One Community - One Child | This grant is designed to focus on campuses in need of community support for the education of its children. | Region 10 ESC selected elementary and Middle schools with low parental involvement. | 19 School districts; 4,031 parent volunteers |
| IHE and Workforce Readiness - Student Excellence and Readiness Through Volunteers in Education (SERVE) | This program is designed to fund an organization with the capacity to provide volunteers to teach classroom or after-school programs to enhance (1) college readiness; (2) workforce readiness; (3) dropout prevention; or (4) personal financial literacy. | The target population for this grant program is at-risk youth. Eligible high school campuses had to be 55% or greater economically disadvantaged. | 21,000 |
| Dropout Recovery Pilot | Designed to identify and recruit students who have dropped out of public secondary schools and provide them the educational and social services needed to assist them in completing a high school diploma or alternative path to college. Program focuses on student outcomes and rewards performance based upon progress and performance of individual students. Grant funds may be used for some social services but only as necessary for students to participate in the Dropout Recovery program. | Students who are 25 years of age or younger and have dropped out of a Texas public secondary school. Cycles 1 and 2 were targeted to the seven ESC regions of the state that had the highest number of dropouts in 2006-2007. Cycle 3 was open for statewide competition. | 2,400 |

| Program Name | Description | Target Population | Number Served Annually |
|---|---|---|---|
| FSP Family, Career, and Community Leaders of America (FCCLA) | This program has substance abuse and school violence components. | Secondary students with a career and technical focus. | 17,500 |
| Avance - Family Support Programs | This program is designed to provide family support and parental involvement in each of their regional centers. | Parents and children 0-7 years old. | 2,500 |
| Life Skills Program for Student Parents Grant | This grant provides services for pregnant and parenting teens. | Female pregnant teens and female and male parents served by Teen Pregnancy and Parenting Programs | 25,095 |
| **Texas Workforce Commission** | | | |
| **Program Name** | **Description** | **Target Population** | **Number Served Annually** |
| Workforce Investment Act (WIA): Adult, Dislocated Worker (DW), and Youth | WIA is designed to improve the quality of the adult workforce through training and education; promote self-sufficiency; reemploy dislocated workers; enhance skill sets; establish new skill sets; and enhance the productivity and competitiveness of all parties. WIA Youth helps eligible low-income youth ages 14 to 21 acquire skills, training, and support to successfully transition to careers through mentoring, training, support services, and incentives. Rapid Response activities provide services quickly to employers, workers, and communities in response to a mass layoff or plant closure. | WIA Adult: Income based eligibility.<br>WIA DW: Job seekers must satisfy the basic WIA eligibility requirements along with satisfying other criteria such as terminated, laid off, or have received a notice of termination or layoff; unlikely to return to the previous occupation or industry; and either eligible for or have exhausted unemployment compensation or ineligible for UI compensation.<br>WIA Youth: Income based eligibility servings youths ages 14 to 21. | 45,151 Adult/DW<br>12,604 Youth |

| Program Name | Description | Target Population | Number Served Annually |
|---|---|---|---|
| Employment Services (ES) | The Employment Service (ES) program provides comprehensive services businesses and job seekers by bringing together employers seeking workers and individuals seeking employment. The ES program coordinates job openings and administers the unemployment insurance (UI) work test to verify that individuals receiving UI benefits are registered for work and are actively seeking employment. ES staff in Texas Workforce Centers provide a variety of services to businesses, including job listing and referral of qualified job seekers; labor market information; interview facilities; job fairs; and information on potential funding for worker training, tax credits, and more. Job seekers receive a variety of services, including referral to job openings, assessment, employment counseling, access to a resource area, labor market information, and seminars on topics such as resume writing, interviewing skills, and job hunting techniques. | Open to anyone. | 1.87 million |
| Child Care | Child Care is a support service for parents who work, attend school, or participate in job training. | Children under 13 years of age in low-income families. Limited to families whose gross monthly income does not exceed 85 percent of the State Median Income (SMI). | 8,077 Choices CC<br>107,333 At Risk/Transitional CC |
| Temporary Assistance for Needy Families (TANF) Employment and Training (Choices) | TANF Choices assist applicants, recipients, non-recipient parents, and former recipients of TANF cash assistance to transition from welfare to work through participation in work-related activities that meet the needs of local employers. | Individuals eligible to receive Choices services including adult or teen heads of household who are applicants, conditional applicants, recipients, non-recipient parents, former recipients, or sanctioned family. | 43,345 |

| Program Name | Description | Target Population | Number Served Annually |
|---|---|---|---|
| Supplemental Nutrition Assistance Program (SNAP) Employment and Training (E&T) | The SNAP E&T program assists SNAP recipients in obtaining employment or education and training activities that will promote long-term self-sufficiency. The key components of the program are job search and job readiness activities, workfare, work experience, non-vocational education, and vocational training. The program also provides participants with support services such as child care and transportation. | SNAP recipients eligible for SNAP E&T services: Adults Without Dependents (ADAWDs) ages 18-50 years of age and SNAP mandatory work registrants and exempt SNAP household members ages 16 -60 years of age (General Population). | 30,031 |
| Project RIO (Reintegration of Offenders) | Project RIO identifies opportunities for employment for adult ex-offenders sentenced to the Texas Department of Criminal Justice (TDCJ) and adjudicated youth committed to the Texas Youth Commission (TYC) that are reintegrating into society. Project RIO provides a continuum of services to assist ex-offenders in successfully transitioning from incarceration to self-sufficiency and independence. | TDCJ Ex-Offenders and TYC Adjudicated Youth. | 54,368 |
| **Texas Youth Commission** | | | |
| **Program Name** | **Description** | **Target Population** | **Number Served Annually** |
| *Rehabilitation and Reintegration* | | | |
| **Specialized Treatment** | | Youth committed to TYC | 1,788 |
| Capital & Serious Offender Treatment | 24-week dorm-based structured program to facilitate cognitive, emotional, and social development and emotional regulation to improve interpersonal functioning. | Youth committed to TYC | 103 |
| Sex Offender Treatment | 12-18 month dorm-based program of motivational techniques coupled with intensive pychotherapeutic groups. | Youth committed to TYC | 382 |
| Chemical Dependency Treatment | 6 month dorm-based program to address underlying emotional dynamics and CD issues. | Youth committed to TYC | 836 |
| Mental Health Treatment | For serious diagnoses that do not respond to general programming. Enhanced psychiatric and psychological assistance of small caseloads with trained direct care staff. | Youth committed to TYC | 1,033 |

| Program Name | Description | Target Population | Number Served Annually |
|---|---|---|---|
| **General Rehabilitative Programming** | | Youth committed to TYC | 2,220 |
| CoNEXTions | An integrated, system-wide rehabilitative program offering various therapeutic techniques and tools. Costs are embedded across strategies. | Youth committed to TYC | 2,220 |
| *Health Care* | | | |
| Health Care Services | UTMB contract costs at facilities and halfway houses for the delivery of on-site primary care and formulary medications. Includes health care services provided by local providers for youth placed in residential contract care programs. | Youth committed to TYC | 2,220 |
| Mental Health Services | The strategy includes clinical personnel to monitor the delivery of health care services, evaluate the performance, and measure the indicators in accordance with community and national standards as well as remain compliant with ACA accreditation standards. | Youth committed to TYC | N/A |
| Health Care Oversight | UTMB contract costs at TYC facilities and halfway houses as part of a comprehensive health care delivery to provide evaluation and treatment of mental illnesses. Also includes mental health services provided by local psychiatrists for youth placed in residential contract care programs. | Youth committed to TYC | N/A |
| *Education and Workforce* | | | |
| Academic, GED, and workforce preparation | Year-round educational programs and services by certified teachers. This strategy supports improved reading and mathematics functioning, completion of a high school diploma or GED, and youth acquisition of workforce skills training. | Youth committed to TYC | 1,896 |
| *No Kidding* | | | |
| Volunteer Services | Services include Financial Skill and Leisure Skill Building, Mentoring, Tattoo Removal, Tutoring, 12-step programs, and other services. | Youth committed to TYC | N/A |

Interim Charge #3: *Review the timeliness and efficiency of the Health and Human Service Commission's eligibility system. Include a review of staffing levels and staffing distribution; implementation of Rider 61; and the increased demand on the system. Make recommendations to improve the efficiency and effectiveness of the system, focusing on policy changes that will not create a large financial burden for the state.*

# Section I. Background

In 2003, the Texas Legislature undertook an unprecedented restructure of the state's health and human services (HHS) system with the goal of creating an integrated, effective, and accessible system for services and supports for Texans in need. The restructure consolidated 12 state agencies into the five agencies that comprise the state's HHS system today:

- Health and Human Services Commission (HHSC)
- Department of Family and Protective Services (DFPS)
- Department of Aging and Disability Services (DADS)
- Department of Assistive and Rehabilitative Services (DARS)
- Department of State Health Services (DSHS) [1]

Under this restructure, the Legislature also gave HHSC responsibility for determining eligibility for Medicaid, the Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), and financial eligibility for Medicaid long-term care for the elderly and individuals with disabilities.[2] As a result, HHSC's eligibility system is the access point for services and supports for millions of Texans. Table 1 provides a brief description of these major state benefit programs. For more information about these and other programs available to Texans, see HHSC's website at: www.hhsc.state.tx.us/help/index.html.

**Table 1. Major State Benefit Programs**

| Program | Description |
|---|---|
| Medicaid | Health insurance program primarily for low-income children and pregnant women, the elderly, and individuals with disabilities. |
| Children's Health Insurance Program (CHIP) | Health insurance program for children under 19 years of age whose families have low incomes and resources but earn too much to receive Medicaid and do not have private health insurance.[3] |
| Temporary Assistance for Needy Families (TANF) | Provides financial help for children and their parents or relatives who are living with them. Monthly cash payments help pay for food, clothing, housing, utilities, furniture, transportation, telephone, laundry, household equipment, medical supplies not paid for by Medicaid, and other basic needs.[4] |
| Supplemental Nutrition Assistance Program (SNAP) | Provides low income individuals and families with electronic benefits they can use as cash to purchase food.[5] |

While HHSC's eligibility system has struggled for years to keep up with the demand for services, system performance reached critical levels in the fall of 2009, particularly for SNAP, formerly called "food stamps." In September 2009, the federal Food and Nutrition Service (FNS), which oversees state administration of SNAP, sent a letter to HHSC indicating possible loss of federal

funds if wait times did not improve. Morale plummeted as eligibility determination and support staff worked evenings and weekends to keep up with incoming applications.

However, it was also during this time that HHSC, under the leadership of newly appointed Executive Commissioner Thomas Suehs, began a drastic turnaround of its eligibility system. While the agency's progress over the past year has been commendable, much work remains to achieve an integrated, effective, and accessible eligibility system.

# Section II. Analysis

In determining how to improve the efficiency and effectiveness of the eligibility system, it is important to understand:

- current system performance;
- factors contributing to system performance issues;
- actions already taken by the state to improve system performance; and
- future expectations of the eligibility system.

## Current System Performance

This section provides an overview of current eligibility system performance compared to last year. Because an independent contractor determines CHIP eligibility, and TANF has a significantly smaller caseload, this section focuses on the state's performance in processing SNAP and Medicaid applications.

### *Timeliness*

Timeliness rates measure the percent of applications processed within the required timeframe. As Table 2 indicates, the required timeframe varies by program and even within each program. States must process 95 percent of applications within the timeframe to comply with federal requirements.

**Table 2. Timeliness Standards**

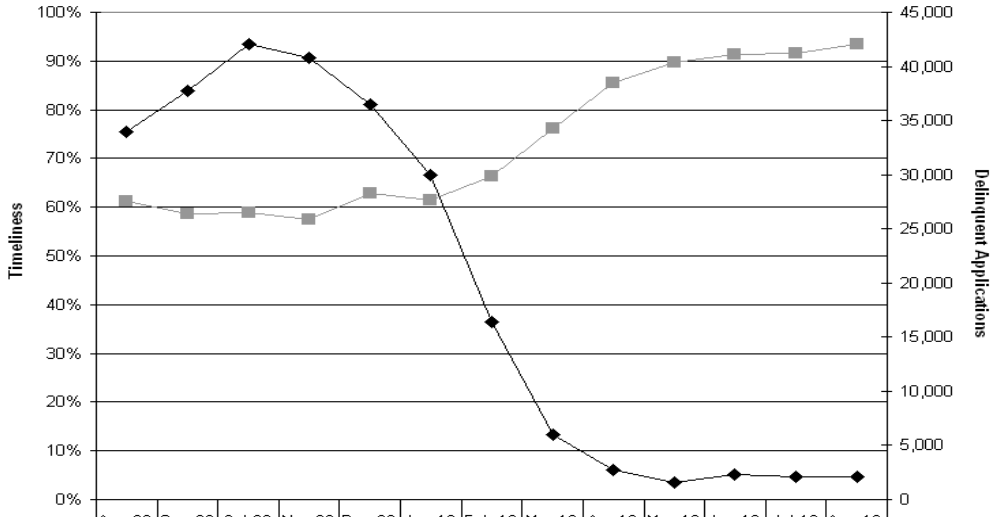
| Program | Description | Required Timeframe |
|---|---|---|
| SNAP (non-expedited) | Regular food assistance | Applications must be processed within 30 days. |
| SNAP (expedited) | Emergency food assistance for families with little to no income and resources | Federal standard: Applications must be processed within 7 days.<br>State standard: Applications must be processed within one business day. |
| SNAP (re-certifications) | Renewal of SNAP benefits | Renewal forms received by the 15th of the last month of certification must be completed by end of the month; 30 day timeframe applies for forms received after the 15th. |
| Texas Works Medicaid | Medicaid for Women, Children, Youth, and Needy Families | Applications must be processed within 45 days, unless applying on basis of disability (90 days) or pregnant (15 days). |

SNAP Timeliness

- In September 2009, HHSC processed 58.6 percent of total SNAP applications timely; in August 2010, this number had improved to 93.5 percent.
- In September 2009, HHSC processed 68.9 percent of SNAP re-certifications timely; in August 2010, this number had improved to 95.8 percent.
- At the federal standard of seven days, HHSC's timeliness for expedited SNAP applications improved from 89.4 percent in September 2009 to 93.9 percent in August 2010.
- At the more stringent state standard of one business day, HHSC's timeliness for expedited SNAP applications improved from 76.6 percent in September 2009 to 88.8 percent in August 2010.[6]

Figure 1 compares SNAP timeliness rates to the number of delinquent SNAP applications from August 2009 to August 2010.[7] In October 2009, the number of delinquent SNAP applications reached a high of 42,081. By August 2010, this number had decreased to 2,097. According to HHSC, some delinquent cases are unavoidable due to factors such as incomplete applications and missed appointments.[8]

**Figure 1. SNAP Timeliness**



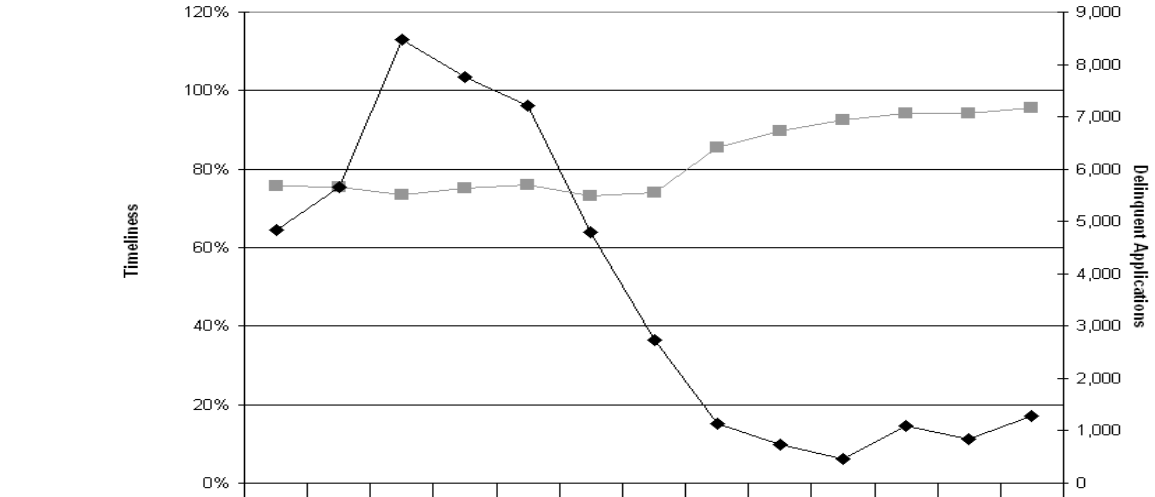

| | Aug-09 | Sep-09 | Oct-09 | Nov-09 | Dec-09 | Jan-10 | Feb-10 | Mar-10 | Apr-10 | May-10 | Jun-10 | Jul-10 | Aug-10 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Timeliness | 61.3% | 58.6% | 58.8% | 57.5% | 62.8% | 61.6% | 66.3% | 76.2% | 85.6% | 89.6% | 91.3% | 91.6% | 93.5% |
| Delinquent Applications | 33,933 | 37,791 | 42,081 | 40,773 | 36,492 | 29,968 | 16,380 | 6,025 | 2,740 | 1,539 | 2,358 | 2,154 | 2,097 |

*For Number Delinquent, SAVERR cases only are reflected through May 2010. TIERS cases included effective June 2010.

Medicaid Timeliness

From September 2009 to August 2010, timeliness for Medicaid also improved, increasing from 75.4 percent to 95.7 percent, as depicted by Figure 2.[9,10] Like SNAP, the number of delinquent Medicaid applications also improved as timeliness increased.

**Figure 2. Medicaid Timeliness**




| | Aug-09 | Sep-09 | Oct-09 | Nov-09 | Dec-09 | Jan-10 | Feb-10 | Mar-10 | Apr-10 | May-10 | Jun-10 | Jul-10 | Aug-10 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Timeliness | 75.8% | 75.4% | 73.4% | 75.1% | 75.9% | 73.2% | 74.1% | 85.4% | 89.7% | 92.5% | 94.2% | 94.1% | 95.7% |
| Delinquent Applications | 4,830 | 5,647 | 8,471 | 7,765 | 7,215 | 4,787 | 2,744 | 1,128 | 746 | 463 | 1,096 | 836 | 1,288 |

*For Number Delinquent, SAVERR cases only are reflected through May 2010. TIERS cases included effective June 2010.

### *Error Rates*

There are two types of SNAP error rates: positive and negative. Positive (also called "payment") error rates occur when benefits are over- or under-issued compared to the amount the household was entitled to receive. For federal fiscal year (FFY) 2009, Texas' positive error rate was 6.9 percent compared to the national average of 4.36 percent. Negative error rates occur when a SNAP application is incorrectly denied, suspended, or terminated. For FFY 2009, Texas' negative error rate was 14.82 percent, compared to the national average of 9.41 percent.[11]

A state is subject to federal penalties when it exceeds the national positive error rate by five percent or more for two consecutive years. On June 24, 2010, Texas received notification from FNS that for FFY 2009, the state was out of compliance for the second consecutive year, subjecting the state to a potential fine of $3.96 million.[12] In August of 2010, HHSC appealed the fine citing uncontrollable events, including Hurricane Ike and caseload growth, as contributing factors to the state's error rates.[13] The state and FNS have since reached a settlement that takes into account Texas' improvement since 2009. As long as Texas is in compliance for FFY 2010, it will not be subject to the fine. Data for FFY 2010 is preliminary but encouraging. Table 3 compares Texas SNAP error rates for FFY 2009 to FFY 2010.[14]

**Table 3. SNAP Error Rates**

| | FFY 2009 | FFY 2010 | | | |
|---|---|---|---|---|---|
| | Oct-Sep | January | February | March | April |
| **SNAP Positive Error Rate** | 6.9% | 1.94% | 2.16% | 1.95% | 1.87% |
| **SNAP Negative Error Rate** | 14.82% | 6.80% | 6.08% | 6.24% | 5.63% |

## Factors Contributing to System Performance Issues

### *Caseload Growth*

In 2009, states across the nation experienced increases in the number of households applying for SNAP due to the economic recession. In Texas, natural disasters also contributed to the higher application rates and increased eligibility workload. The U.S. rate of first time applications for SNAP increased by 14.5 percent between FFY 2006 and 2008. Over this same period, Texas' rate increased by 55.2 percent, the greatest increase of all states.[15]

The Texas statistics are staggering:

- HHSC issued $433.49 million in SNAP benefits in August 2010 compared to $343.92 million in August 2009, a one-year increase of 26 percent.[16]
- HHSC issued benefits to more than 3.47 million recipients in August 2010, compared to 2.8 million recipients in August 2009, a one-year increase of 23.9 percent.[17]
- In August 2010, Texas had a total of 3.1 million individuals enrolled in Medicaid compared to 2.8 million in August 2009, an 11.9 percent increase.[18]

### *Staffing*

Higher caseloads and fewer tenured staff have complicated HHSC's efforts to rebuild and retain its eligibility workforce and were major contributors to timeliness and accuracy issues in 2009. To work through the backlog of applications, eligibility staff worked evenings and weekends, resulting in low staff morale and exhaustion. In September 2009, eligibility staff worked more than 227,000 hours of overtime, which is equivalent to 1,420 FTEs, or 30 percent of the existing eligibility workforce. During this time, eligibility workers earned on average about 50 hours of overtime per month, or 13 hours per week.[19] Supervisors are not eligible to receive overtime pay, but received compensatory time.[20]

Due to the complexity of the eligibility determination process, it takes at least two years for HHSC to fully train new staff. However, in 2009, less than half of eligibility workers had more than two years experience, compared to over 90 percent just five years earlier. In 2004, 95.4 percent of supervisors had more than one year of experience in that role. By 2009, this figure had dropped to approximately 67 percent.[21]

### *Use of Multiple Computer Systems*

In the 1970s, Texas became one of the first states to implement an automated system to help its staff determine client eligibility when it deployed the System of Application, Verification, Eligibility, Referral, and Reporting (SAVERR).[22] Almost 40 years old, the SAVERR system uses outdated computer technology that is difficult and expensive to maintain and update.

In 1999, recognizing the need to modernize the eligibility automation system, the Legislature directed what was then the Department of Human Services (DHS) to plan and develop the Texas Integrated Eligibility Redesign System (TIERS), with a focus on redesigning and replacing SAVERR and other automated systems providing eligibility determination and enrollment functions for the Medicaid, Food Stamp, TANF, and long-term care programs. In June 2003, TIERS was deployed in eligibility offices in Travis and Hays counties on a pilot basis.[23]

Unlike SAVERR, TIERS is a web-based system that was designed to support an integrated approach to eligibility. Its technology strengthens fraud prevention and increases confidence in the state's ability to accurately determine eligibility and benefits. For example, TIERS:

- collects information about the client and then applies the same data for all programs to maintain quality control;
- creates an electronic record that follows the client;
- allows casework to be distributed between offices to balance workload, which is particularly useful during natural disasters;
- makes changes in real-time which are instantly accessible to other workers and entities that interface with the system; and
- automatically and uniformly applies program policies, like household composition and budget calculations, rather than relying on the worker to apply the appropriate policy.[24]

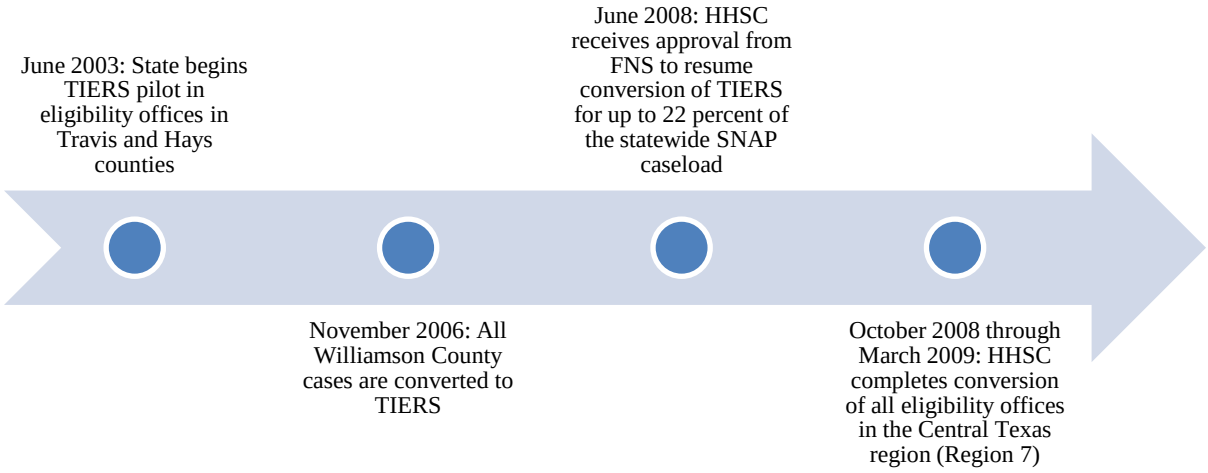
After a series of setbacks following an effort to contract out some of the eligibility system functions, the 80th Legislature directed HHSC to develop a transition plan to transform and enhance the eligibility system. The overarching goals of this modernization were to expand service options for consumers and make better use of taxpayer dollars. The Legislature specified that this modernized system should:

- increase the quality of and client access to services;
- implement more efficient business processes to reduce processing times and staff workloads;
- implement simplified application and enrollment processes;
- enhance integrity and reduce fraud; and
- ensure compliance with federal laws and rules.

As Figure 3 indicates, transition from SAVERR to TIERS moved slowly from June 2003 to March 2009.[25] As a result, eligibility staff has operated in two different computer systems, a costly and inefficient process. Operating in two systems requires that any system or policy changes be made in two systems. HHSC must also develop and provide training for the two different systems. Additionally, TIERS clients remain in TIERS even if they move to an area of the state where TIERS has not yet been deployed, necessitating that each office in the state have workers trained in TIERS.[26]

For a discussion on the state's progress in transitioning to TIERS since March 2009, see the following section on "State Actions to Improve System Performance."

**Figure 3. TIERS Transition Timeline (2003-2009)**




## State Actions to Improve System Performance

### System Reviews

HHSC's performance issues prompted several reviews of the HHSC eligibility system, including an audit by the State Auditor's Office (SAO) requested by Executive Commissioner Suehs in December 2009. As a result of these reviews, HHSC developed the *Comprehensive Management Improvement Plan* (CMIP). This plan incorporates eligibility-related projects identified as a result of the SAO audit, HHSC's *Supplemental Nutrition Assistance Program Corrective Action Plan* required by FNS, the FFY 2009 *Federal Portion of the Statewide Single Audit Report*, and internal reviews. The CMIP is intended to guide and monitor improvements in timeliness, accuracy, and customer service, and to establish business processes that are both cost-effective and sustainable.[27] A copy of the CMIP is included in the Appendix.

HHSC is also reviewing existing procedures and policies to maximize efficiency and ensure that performance does not suffer as caseloads continue to grow. Specifically, HHSC is analyzing options that will maximize the use of technology, improve customer service, and ensure program integrity. Some of the options being reviewed by HHSC include:

- providing an option for clients to receive notifications electronically rather than by mail;
- developing a phone or web-based system to automate client interviews;
- expanding the use of electronic verifications to reduce the need to follow-up with applicants, which can delay benefits; and
- aligning program policies where possible to aid eligibility workers in completing eligibility determinations.[28]

During the September 8th joint hearing between the Senate Committee on Health and Human Services and the Joint Legislative Oversight Committee on HHS Eligibility, Commissioner Suehs discussed ways the state may be able to restructure some of its benefit offices. He suggested that, in some cases, larger offices could be split into several smaller offices so they are located closer to the client base.

**Staffing**

For fiscal years 2010-2011, the 81st Legislature authorized HHSC to maintain 9,039 eligibility and support staff. Rider 61 (S.B. 1, 81st Legislature, Regular Session) also authorized HHSC to request up to 656 additional eligibility staff for fiscal year 2010 and another 166 for fiscal year 2011 from the Legislative Budget Board (LBB). On August 13, 2009, HHSC requested approval from the LBB to increase the staffing cap by 649 FTEs. On October 2, 2009, the LBB directed HHSC to fill all vacancies and authorized an additional 250 FTEs, bringing HHSC's total authorized staff to 9,289.[29] As of August 12, 2010, HHSC had a net gain of 864 eligibility determination staff since September 1, 2009.

Recognizing that HHSC was not managing its vacancy rate well, Commissioner Suehs authorized a level of staff slightly higher than the amount authorized by the LBB to compensate for turnover. This method allows HHSC to "hire-ahead" so that the agency can maintain staffing at the FTE cap. Table 4 compares the eligibility staff authorized by the LBB to that authorized by Commissioner Suehs. The 9,733 level authorized by Commissioner Suehs accounts for a 4.5 percent vacancy rate.[30]

**Table 4. Authorized Eligibility Staff**

| | Authorized FTEs | Positions Authorized by Executive Commissioner Suehs |
|---|---|---|
| **Strategy A1.2 Authorized** | 9,039 | N/A |
| **Rider 61b Authorized** | 250 | N/A |
| **Total FTEs Authorized** | 9,289 | 9,733 |

Although Commissioner Suehs has authorized a staffing level higher than that authorized by the LBB, HHSC is still within the LBB's authorization for the fiscal year. Table 5 shows that although HHSC had more filled staff positions in August 2010 than authorized by the LBB, HHSC is still 81 positions short of the total LBB authorization for the fiscal year.[31]

**Table 5. Filled Eligibility Staff**

| | HHSC Filled Positions | LBB Authorized FTEs | Variance |
|---|---|---|---|
| **Filled Eligibility Positions as of August 12, 2010** | 9,319 | 9,289 | 30 |
| **Average Year to Date Filled Eligibility Positions** | 9,208 | 9,289 | -81 |

HHSC also initiated a number of immediate changes within existing resources to quickly address the state's application backlog. For example:

- more tenured staff were paired with new staff to process applications in teams;
- support staff from DFPS were used to reinforce HHSC staff;
- retired eligibility workers returned to assist with the backlog;
- eligibility staff promoted to other positions returned to help with processing applications; and
- HHSC obtained federal approval to conduct phone, rather than face-to-face, interviews when possible.

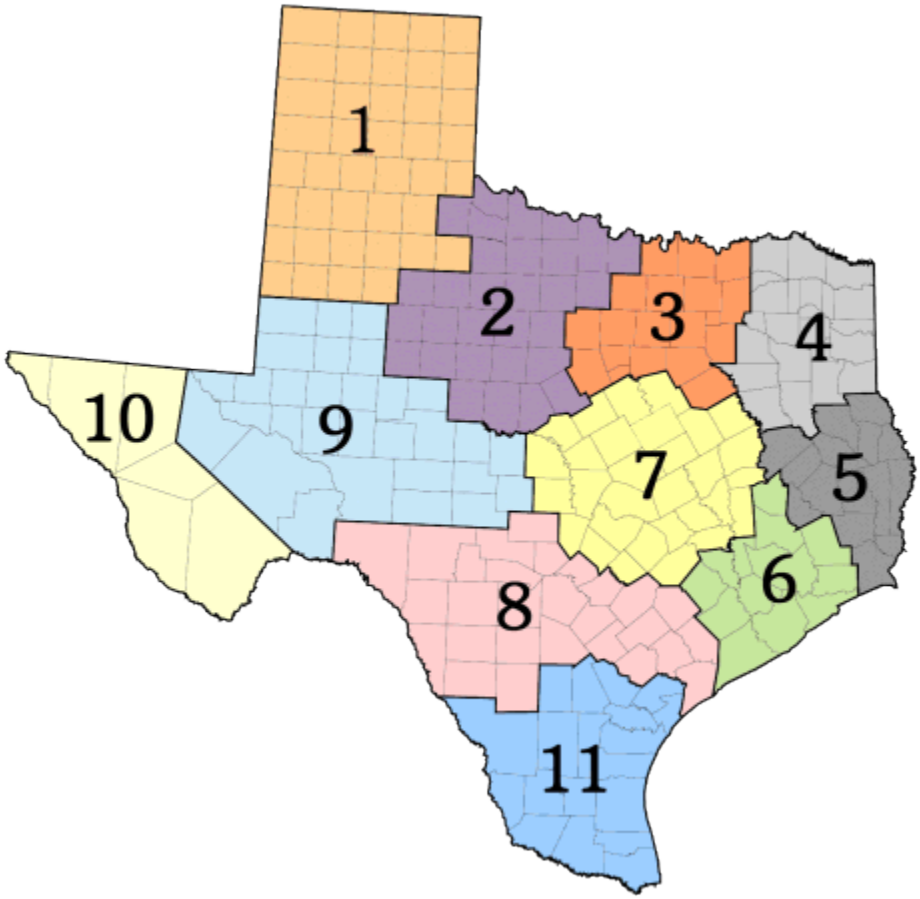
Several staffing initiatives also addressed low staff morale and overtime. For example:

- HHSC solicited feedback and recommendations from eligibility staff through regional meetings, visits to local offices, and email;
- Commissioner Suehs agreed to cook lunch for offices showing best or most improved performance ("Commissioner's Challenge");
- eligibility workers received a one-time merit payment; and
- mandatory overtime was suspended during the holiday season.

**Resuming TIERS Transition**

As part of the Texas *Supplemental Nutrition Assistance Program Timeliness Corrective Action Plan*, FNS recommended that Texas consult with other states for suggestions on managing increasing caseloads with limited resources. FNS asked Stanley Stewart, Chief Deputy Director of the Michigan Department of Human Services, to review activities in the Texas eligibility system and advise HHSC on next steps for further rollout of TIERS. Mr. Stewart had recently overseen a similar transition in Michigan. At this time, only one of the 11 Texas HHS regions, Region 7 (Central Texas), had been converted to TIERS. The following map illustrates the state's 11 HHS Regions.[32]

**Figure 4. Texas HHS Regions**



Like Texas, Michigan had been using an antiquated automation system for eligibility determination. Using the computer code from Texas' TIERS system, Michigan created the Bridges system.[33] In 2007, Michigan began planning its conversion from its legacy system to Bridges. Conversion began in August 2008 and was completed in 2009. During the transition, conditions in Michigan were not too different than in Texas; caseload growth was at an all-time high due to the economy, the state was facing budget constraints, and the unemployment rate rose to 14.8 percent.[34]

In November of 2009, Stanley visited with HHSC and made a number of observations about the Texas eligibility system:

- Operation of two systems is expensive, problematic, and the biggest hindrance to the delivery of essential services in Texas.
- No one person was in charge of the TIERS project, resulting in silos and a lack of communication within HHSC.
- There was a lack of input from local offices, which can help identify problems with usability.
- Training plays a critical role in the success of TIERS; however, training staff did not seem to recognize the importance of their work.
- The lack of server capacity needed to be resolved so the state could move forward with the transition.[35]

Following his visit, HHSC hired Stanley Stewart to oversee the TIERS transition in Texas. Stanley has used his experiences and lessons learned in Michigan to help Texas move forward with conversion from SAVERR to TIERS. As a result, Texas has made significant progress in its TIERS transition.

In May 2010, HHSC received conditional approval from FNS to rollout TIERS to five additional regions:

**Table 6. Federally Approved TIERS Rollout**

| Region | All Programs SAVERR Cases (excluding MEPD) | SNAP SAVERR Cases | Proposed Rollout Date |
|---|---|---|---|
| Region 1 - Lubbock | 70,041 | 34,157 | COMPLETED |
| Region 10 - El Paso | 118,843 | 63,066 | COMPLETED |
| Region 5 - Beaumont | 82,834 | 45,630 | COMPLETED |
| Region 4 - Tyler | 106,331 | 55,549 | COMPLETED |
| Region 2/9 - Abilene | 96,732 | 49,372 | January 2011 |

Following each conversion, HHSC monitors performance closely through:

- daily conference calls with local staff, management, and programmers for the first month after rollout;
- daily monitoring of technical performance;
- comparison of total benefits issued before and after conversion;
- tracking of timeliness at each office;
- availability of experienced TIERS workers to assist with cases as needed; and
- senior management present on-site throughout the rollout.

The conversion plan for the remaining regions is currently being reviewed and will require federal approval. Statewide conversion is targeted for completion by the end of 2011.

As policymakers prepare for the upcoming legislative session, it is important to note that until the entire state is operating in TIERS, any eligibility policy change will have to be programmed into both systems, creating duplicative work. Legislators can assist HHSC with the TIERS transition by delaying policy changes, when feasible, until the transition to TIERS is complete.

**Strengthening Community Partnerships**

Since 2006, HHSC has awarded grants to Texas food banks to expand assistance available to low-income individuals who need help applying for benefits. This partnership has been very successful; applications received by HHSC from food banks are more likely to be accurate and complete.[36] Last fall, HHSC authorized additional funding to expand application assistance activities with the Texas Food Bank Network (TFBN).[37]

Additionally, Texas requested federal approval for a five-year pilot project that will allow highly trained TFBN staff to conduct interviews for clients seeking SNAP benefits. Current federal regulations require these interviews to be completed by state staff; however, FNS granted Texas a waiver to allow TFBN staff to fulfill this requirement. Eligibility determination is still done by HHSC staff. This pilot gives individuals another option for applying for SNAP, allowing them to apply in their community where they may feel more comfortable, rather than at a state eligibility office. It also streamlines the application process for applicants and increases timeliness. The pilot began on March 1, 2010 in three pilot areas: Dallas/Fort Worth, Houston, and San Antonio. As reflected in Table 7, initial data from the pilot sites indicates that applications are being processed timely.

**Table 7. Food Bank Pilot Timeliness**

| | Expedited SNAP Timeliness | | Non-Expedited SNAP Timeliness | |
|---|---|---|---|---|
| **Benefit Month** | **Number Disposed** | **Disposed Timely** | **Number Disposed** | **Disposed Timely** |
| March 2010 | 75 | 100% | 107 | 98.1% |
| April 2010 | 195 | 100% | 320 | 96.9% |
| May 2010 | 232 | 96.5% | 468 | 96.6% |

At the September 8th joint hearing, members of the committees expressed interest in expanding partnerships with community-based organizations (CBOs). HHSC is currently seeking input and guidance from a variety of CBOs who have expressed interest in partnering with the state to assist clients in applying for benefits and plans to develop pilots in fiscal year 2011.

## Future Expectations of the Eligibility System

### TIERS Transition

H.B. 3859 (81st Legislature, Herrero) directed HHSC to conduct an analysis of staffing needs for the enhanced eligibility system and expansion of TIERS. Because the system is in transition, an accurate staffing model was difficult to develop.[38]

The analysis did find that when an application is submitted in-person, there is no significant difference in productivity between SAVERR and TIERS. However, when applications are submitted online, there are productivity gains from using TIERS. HHSC's current online application for benefits still requires workers using SAVERR or TIERS to manually enter information from an application submitted online. However, TIERS has the capability to accept information from an online application directly, reducing the need for manual entry by staff, a feature SAVERR does not have. In early 2011, HHSC expects to implement an expanded "self-service" portal that will take advantage of this TIERS capability.[39] The portal will also allow CBOs to more easily assist Texans with applications for benefits.

During the committee's hearing, Senator West recommended that as the state moves toward a web-based "self-service" system, it ensure that applicants have access to the new option in their community.

### Federal Health Care Reform

In 2014, federal health care reform will expand Medicaid eligibility to 133 percent of the federal poverty level, adding an estimated 1.2 million newly eligible Texans to the HHSC eligibility system.[40]

According to Commissioner Suehs, the biggest challenge in preparing the eligibility system for federal health care reform in 2014 is understanding the capacity necessary for both the current HHSC eligibility system and the future health insurance exchange required by the federal legislation. A health insurance exchange works as a marketplace for individuals and employers to purchase health insurance. Under the new law, HHSC's eligibility system and the health insurance exchange are required to coordinate, creating a seamless, "no wrong door" entry into the state's health insurance system. The capacity needed is difficult to estimate because it will depend on how people choose to access the system, and human behavior is difficult to predict. However, Commissioner Suehs said he hopes to have a rough estimate of future eligibility staffing needs related to federal health care reform by the end of the year.

## Legislative Considerations

In light of the state's eligibility system performance last year, some groups have called for the state to relax existing eligibility policies. Specifically, FNS and advocates for low-income Texans have recommended eliminating finger imaging of SNAP applicants and the SNAP asset test.

**Finger Imaging**
Finger imaging is intended to prevent individuals from receiving SNAP benefits under multiple names. Federal law does not require states to use finger imaging; however, Texas has required it through state law as a fraud deterrent tool. In most cases, all household members over the age of 18 must be finger imaged at a local HHSC eligibility office. As the state continues to modernize the eligibility system with tools like the TIERS "self-service" portal, the need for applicants to visit eligibility offices will decrease. The finger imaging requirement will continue to require that applicants travel to eligibility offices.

While the potential for technology to streamline eligibility processes and increase client access to the system is abundant, it will need to be balanced with ensuring integrity of the system.

**SNAP Assets Test**
Asset tests are intended to ensure that benefits go to truly needy applicants. The SNAP asset test is not required by state law, rather by agency regulation. However, although state law does not dictate this requirement, any changes to the asset test will likely need to come from the Legislature. Currently about one percent of all SNAP denials are for applicants exceeding the assets allowance.[41]

# Section III. Conclusion

Over the past year, HHSC has made great strides in improving its eligibility determination performance as evident by increases in timeliness and accuracy. To ensure that the eligibility system is prepared for future needs, HHSC should continue its efforts. Specifically, HHSC should continue reviewing existing policies and procedures and identify changes to maximize efficiency and performance; continue efforts to rebuild and retain the eligibility workforce; and proceed with the statewide transition to TIERS.

# Section IV. Recommendations

1. **The Health and Human Services Commission should continue current efforts to review existing policies and procedures; rebuild and retain its eligibility workforce; and complete statewide transition to TIERS.**

2. **The Legislature should limit eligibility policy changes, when feasible, until statewide transition to TIERS is complete.**

3. **The Health and Human Services Commission should work to ensure that applicants have access to the TIERS "self-service" portal in their communities.**

4. **The Health and Human Services Commission should continue to strengthen partnerships with community-based organizations to increase options available to Texans in need of assistance.**

[1] Health and Human Services Commission. (2007). *About the Texas Health and Human Services System*. Available: http://www.hhs.state.tx.us/aboutHHS/texasSystem.shtml, Accessed: October 22, 2010.
[2] Health and Human Services Commission, *House Bill 3575: Health and Human Services Eligibility System Transition Plan,* p4, October 2007.
[3] Health and Human Services Commission. *Health Care Coverage: Children and Youth*. Available: http://www.hhsc.state.tx.us/Help/HealthCare/Children/index.html, Accessed: October 26, 2010.
[4] Health and Human Services Commission. *Temporary Assistance for Needy Families*. Available: http://www.hhsc.state.tx.us/Help/Financial/Temporary_Assistance.html, Accessed: October 26, 2010.
[5] United States Department of Agriculture, Federal Nutrition Service. *Supplemental Nutrition Assistance Program.* Available: https://www.fns.usda.gov/SNAP/faqs.htm#1, Accessed: October 28, 2010.
[6] Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services and the Joint Committee on Oversight of HHS Eligibility System*, p4, (Austin, TX, September 8, 2010).
[7] *Id.* at p5.
[8] Commissioner Suehs, Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services and the Joint Committee on Oversight of HHS Eligibility System*, (Austin, TX, September 8, 2010).
[9] Health and Human Services Commission, *supra* note 6 at page 6.
[10] *Id.* at p7.
[11] *Id.* at p16.
[12] *Id.*
[13] *Id.* at p17.
[14] *Id.* at p18.
[15] *Id.* at p21.
[16] *Id.* at p4.
[17] *Id.*
[18] *Id.*at p6.
[19] Health and Human Services Commission, *Eligibility Services Weekly Progress Report*, November 5, 2009, p18.
[20] *Id.*
[21] Health and Human Services Commission, *Eligibility Update*, p2, October 26, 2009.
[22] Health and Human Services Commission, *HB 3575 Eligibility Transition Plan*, p7, October 2007.
[23] *Id.* at p8-9.
[24] *Id.* at p16.
[25] Health and Human Services Commission, *supra* note 6 at p11.
[26] Health and Human Services Commission, *supra* note 22 at p26.
[27] Health and Human Services Commission, *supra* note 6 at p27-28.
[28] *Id.* at p31.
[29] Health and Human Services Commission, *supra* note 21 at p8.
[30] Health and Human Services Commission, *supra* note 6 at p10.
[31] *Id.*
[32] Health and Human Services Commission. *Health and Human Services Regions*. Available: http://www.hhs.state.tx.us/aboutHHS/HHS_Regions.shtml, Accessed: November 29, 2010.
[33] Health and Human Services Commission, *Testimony before the Joint Committee on Oversight of HHS Eligibility System,* p3, (Austin, TX, March 11, 2010).
[34] *Id.* at p4.
[35] Stanley Stewart, *Presentation at Joint Committee on the Oversight of HHS Eligibility Staff Briefing,* November 20, 2009.
[36] "Food Bank Pilot Gives Families New Way to Apply for SNAP." *In Touch: News from The Health and Human Services Commission*, March/April 2010.
[37] Health and Human Services Commission, *Supplemental Nutrition Assistance Program Timeliness Corrective Action Plan, Federal Fiscal Year 2010.* p11.
[38] Health and Human Services Commission, *supra* note 6 at p12.
[39] *Id.* at p27.
[40] *Id.* at p31.

[41] Information provided by Health and Human Services Commission staff, October 12, 2010.

# Appendix

## Comprehensive Management Improvement Plan (CMIP): Status Update

In May 2010, the Texas Health and Human Services Commission (HHSC) finalized a comprehensive plan to improve the timeliness, accuracy, and efficiency of Texas' eligibility system for Supplemental Nutrition Assistance Program (SNAP) food benefits, Medicaid, and cash assistance. This plan incorporates HHSC management initiatives, as well as recommendations from the State Auditor's Office, the statewide single audit, and the U.S. Department of Agriculture Food and Nutrition Services SNAP Corrective Action Plans.

The Comprehensive Management Improvement Plan includes approximately 60 recommendations and more than 70 related action plans that cover the following categories and topics:

- Communication with Clients – phone systems, signage, forms, and Internet and web-based communication;
- Clerical Support – roles and responsibilities, improved training, and increased focus on customer service and support of the business process;
- Workforce Management – productivity standards, hiring and retention, new hire mentoring, and evaluation and improvement of worker training;
- Program Management and Monitoring Improvements – program performance indicators, reports and monitoring practices, system usability and capacity, and employee feedback mechanisms;
- Local Office Business Processes – improved office procedures to more efficiently answer client questions, resolve client issues, and provide services; and
- Process and System Integrity – policies and procedures for case record management, case reviews for required documentation, improved automated controls, and other actions to strengthen program integrity and comply with corrective action plans.

Work plans and related timelines have been reviewed at the executive level. Progress is monitored and issues are resolved by cross-divisional workgroups including executive management every six to eight weeks. Many projects are on target to be implemented this year.

Major accomplishments and projects underway in each of the categories are listed below.

### Communication with Clients

**Major Accomplishments:**

- Increased phone system capacity at 30 of 42 priority eligibility offices (71%), all 42 are on track to be complete by the end of September.

- Surveyed 500 clients and clerks in 40 offices to identify communication improvements. Results indicate:
    - Only about half were already clients; almost 35% were waiting to hear if they would be eligible for benefits.
    - About 30% came in for an interview appointment, and another 35% came in to drop off an application or paperwork.
    - Almost 75% stated that coming to the office or calling the office has been the best way to learn about benefit programs. More than 80% do not use the internet to get information about benefit programs.
    - Almost half (49.7%) can receive e-mails or text messages, but 70.4% of those surveyed would prefer to receive information about benefits through the mail (rather than a phone call, e-mail, text, or request to come into the office).
    - Results are being used to develop a client communication and outreach plan, as well as inform local office business process improvements.

- In March, installed new signs in offices providing information on how to apply.
    - Signs demonstrate alternative processes and are themed "No need to stand in line."

- Developed folders to guide clients through the application and renewal process for SNAP benefits.
    - The folder provides a simple explanation of the process and a place to store needed documents and contact information.
    - Folders are being printed in September.

- Revised forms explaining what to bring to an interview.
    - Improved form is much easier to read and understand.
    - New form has been added to the staff handbook, and will be printed and distributed to offices and clients as supplies of the current form are depleted.
    - Form will also be linked to self-service portal in December.

**Additional Communication Projects Underway:**

- Developing new integrated applications for services.
    - New applications incorporate input from stakeholders, and are easier to read and understand.
    - The Texas Works application is ready, development of new application for Medicaid for the Elderly and People with Disabilities is underway.
    - Both are planned for release with self-service portal updates in April 2011.

- Enhancing the self-service portal.
    - In December 2010, enhancements to the self-service portal will improve the look and feel of the online application and will enable the online application to directly populate TIERS.

- Enhancing the self-service options in the Interactive Voice Response (IVR) System.

- Improving web services to allow callers to obtain additional information about their case including missing information needed, and information about pending, approved or denied case status.

- Evaluating options for several communication improvements including:
  - Kiosks in offices,
  - Text messaging, and
  - Internet and web-based communication with clients.

## Clerical Support

**Major Accomplishments:**

- Developed new Basic Skills Training (BST) for newly hired clerks with emphasis placed on customer service, and clerical roles and responsibilities.
  - New pre-and post activities enhance clerical training with activities such as observing client experiences in the office lobby, attempting to complete an application for services, and practice screening an application for expedited benefits.
  - New hire training (BST) was implemented on August 31, 2010.
  - Basic Skills Training for clerks had not been offered in most areas of the state for the last several years.

- Developed a one-day "refresher" training for tenured clerks emphasizing the skills needed by clerks to answer client questions and best support workers.
  - Training includes inquiry in TIERS and SAVERR, application registration, scheduling, interim conversions, and discussion of the "big picture" so clerks better understand the impact of their actions on the business process and client experience.
  - The implementation schedule for this training is currently being developed.

- Revised TIERS rollout training for clerks (in rollout regions) to include customer service principles and role-playing exercises.
  - Revised training includes additional exercises on TIERS inquiry to assist clerks in answering client questions about the status of their application.
  - New classes began August 9th.

- Improved and distributed a new tool to help clerks screen applicants for expedited SNAP benefits.
  - The new tool incorporated a suggestion for improvement from staff in the Lubbock region.

**Additional Clerical Projects Underway:**

- Creating staffing development plans to provide definition and guidance for supervisors and managers on the roles and responsibilities of clerks.

## Workforce Management

**Major Accomplishments:**

- Conducted staffing analysis to determine eligibility staffing needs associated with the expansion of TIERS (set forth in Texas Government Code, Section 531.4551).
    - Results show growth in HHSC eligibility staffing requirements from 8,419 staff (FY 2010) to 10,610 (FY 2013).
    - Based on number of workers needed to complete the expected number of applications and redeterminations each month in a timely manner, with minimal use of overtime.
    - Assumes productivity measure of 8.5 cases disposed/advisor/day.
    - No additional staff are needed simply because of the transition from SAVERR to TIERS.
    - Additional staff are required to reduce overtime and because of increasing caseloads.
    - Staffing analysis assumes increases in efficiency due to enhancements in the eligibility determination process.

- Assessed eligibility worker compensation and included recommendations for 10% salary increases in the HHSC Legislative Appropriations Request.
    - FY 2010 turnover rate for eligibility workers and clerks is projected to be about 16%. (This is down more than 3% from FY 2009.)
    - Low starting salaries and overtime are among the primary reasons HHSC experiences difficulties retaining qualified staff.
    - A review of market data indicates the starting salary levels for HHSC eligibility workers are not competitive with similar jobs in other states.
    - Median average base salary for a tenured worker in 8 states is $40,761; Texas is $31,735.
    - 41% of workers in FY 2010 have less than 2 years of experience; in FY 2005, only 4.1% of workers had less than 2 years of experience.
    - Past compensation programs indicate an improvement in recruiting and retention of workers.

- Revised and improved Basic Skills Training for all workers, clerks, and supervisors in both the Texas Works and Medicaid for the Elderly and Persons with Disabilities Programs.
    - New training is more "hands on" and includes customer service.
    - All new hire training is now based in TIERS.

- Revised and improved TIERS rollout training for all Texas Works workers, clerks and supervisors.
    - Training is more "hands on" and includes an "On the Job" training component.
    - Classes are based on the TIERS skill level of participants to focus the class and allow condensed training for experienced users.

- Revised job description and essential job functions for Worker IVs to incorporate mentoring activities.

- Reassigned 71 staff from central operations to the regions, and transferred an additional 21 positions to directly assist the regions in preparation for TIERS.

- Reviewed and revised overtime policy to ensure that employees working authorized overtime hours receive appropriate supervision and assistance.

**Additional Workforce Management Projects Underway:**

- Finalizing worker productivity expectations.
    - Will use productivity measures in performance plans and performance evaluations.
    - Currently assuming a productivity measure of 8.5 cases disposed/advisor/day.
    - Considering establishment of productivity ranges that will be tied to different levels of staff evaluation (e.g., x cases disposed/day = meets expectations, y cases disposed/day = exceeds expectations, etc.).
    - Productivity expectations will be used in conjunction with other factors such as timeliness, quality and customer service to determine a final evaluation rating for staff.

- Developing plans for performance-based pay for eligibility staff.
    - Proposed factors include timeliness, customer service, and accuracy.
    - Staff recommendations are for annual one-time merit payments to eligibility staff in field offices and special units. The first awards would be in August 2011.
    - HHSC is now analyzing awarding a one-time merit payment at the Program Manger level with a 3.5% salary award.
    - Consideration will also be given to providing credits or bonus points for staff to encourage assistance outside the program area, and to evaluate the volume and quality of assistance.

- Designing a staff development plan for Texas Works supervisors that includes information and training on mentoring and supporting new worker staff.

- Developing new training for Worker IVs that includes a mentoring component.

- Began piloting a six-month STARK custom pre-screening solution for hiring qualified eligibility staff in the Houston and Arlington regions in April 2010.
    - In the first four months of the pilot, HHSC Human Resources and STARK have narrowed a field of over 22,000 applicants to the top 3.5%, or 771 individuals.
    - As of July 31, 2010, a total of 68 referred applicants have been hired (36 in Region 3 and 32 in Region 6).
    - A targeted initiative to recruit qualified bilingual applicants is underway, but continues to be a challenge.
    - HHSC will evaluate the success of this pilot, as well as look at our own screening processes, to make improvements in hiring qualified staff across the state.

## Program Management and Monitoring Improvements

**Major Accomplishments:**

- Based on staff feedback, implemented more than 20 significant usability improvements to TIERS including: calendar pop-ups so staff can more easily enter dates, more intuitive wording for required items, highlighted sections showing the worker where an error has occurred in data entry, and improvements in the layout of the screens and navigation buttons.
    - Improvements were released in August and have been very well-received across the state.
    - Later in September HHSC will be conducting a statewide survey to assess the enhancements and the training and communication related to these changes.
    - TIERS staff continue to be proactive about making office visits to gather feedback. Plans are in place to visit every region of the state.

- Began converting data from key SAVERR reports into an Excel format and making the data available electronically to regional managers and supervisors.
    - Reports of pending work were available beginning in July; reports for timeliness will be available no later than September 31, 2010.
    - Priority of reports was established by regional directors, and additional reports will be converted as requested.
    - Previously, these SAVERR reports were only available in text format. Hard copy printing and distribution took days or weeks, and information could not be "sorted" to support the individual needs of regional managers.

- Implemented several methods to communicate regularly with front-line staff including:
    - Regional representation on statewide workgroups to develop trainings and staff development plans,
    - State office attendance at regional meetings,
    - All-staff meetings,
    - Staff surveys on training and rollout,
    - Staff involvement in TIERS usability studies,
    - Program Manager workgroups to address issues identified by regional staff, and
    - Designation of 230 "change champions" across the state who are responsible for disseminating information such as TIERS conversion issues and policy changes.
    - Further efforts are underway to improve communication back from the region to state office.
    - Consideration is being given to ways to consolidate communication and updates from state office to local office staff in order to avoid unnecessary distractions away from key job duties in the field.

- Shifted some workload away from centralized Customer Care Centers to better enable the centers to stay current with processing changes.

- Additional evaluation of workload trends and staffing of centralized units is underway.

- Implemented improved review processes for supplemental and restored benefits issued including:
  - Improvements to the nightly EBT monitoring report, facilitating immediate feedback to the advisor and supervisor regarding any errors.
  - Weekly review of supplements and restored benefits issued for validation.
  - Independent quality control review of statistically valid sample of supplements on a quarterly basis to identify any issues and trends.
  - Functionality changes to TIERS to further address this issue by prompting workers to check certain actions that will result in supplemental or restored benefits being issued are planned for implementation in December.

- Completed initial analysis on pended cases to address primary causes for delays in the eligibility determination process.
  - Initial analysis included 160 SNAP cases (40 applications and 40 re-certifications in both SAVERR and TIERS).
  - Forty-one (51%) of sampled applications were pended for verification.
  - Fifty-four (67%) of re-certifications were pended for verification.
  - While only approximately 50% of the re-certifications in TIERS were pended, almost 90% of re-certifications in SAVERR were pended (35 of 40).
  - Of all the cases that were pended, 35% were pended solely for proof of wages and an additional 33% were pended for proof of wages and other items.
  - Additional analysis is underway to better understand the differences in pending under SAVERR and TIERS, and to further reduce delays in the eligibility determination process.

- Implemented policy and automation changes to reduce the number of cases pended.
  - In February 2010, implemented policy requiring advisors to use TWC wage records as proof of wages rather than pending for pay stubs or other employer records. (Early analysis suggests staff are only using this new option about half as frequently as they should, so additional training was provided in August 2010 with training on best practices noted below.)
  - In March, use of the Standards Utility Allowance was mandated so that staff would no longer have to obtain proof of actual utility expenses.
  - Effective September 1, additional policy changes were implemented including revision of policy for TANF/SNAP/Medicaid to allow staff to verify at least three payment stubs (rather than 4-8 as previously required) to use as a basis for estimating fluctuating income, such as wages. These changes should further reduce the number of applications and re-certifications pended for verification of wages, unearned income, residence and resources.
  - A report providing information on pended cases in TIERS has been improved and is in production**.** This report assists supervisors and workers in managing their pended cases**.**

- Best practices training on verification to reduce the number of cases pended was provided in August 2010.

**Additional Program Management Projects Underway:**

- Developing comprehensive eligibility program performance indicators and monitoring process improvements.
  - Completed review of current monitoring report, and identified additional data sources needed.
  - Draft indicators are under review, and include timeliness and pended case information for TANF, as well as for the SNAP and Medicaid programs.
  - Program performance monitoring processes will also be reviewed and improved as needed.

- Conducting cost-benefit analysis to evaluate possible improvements to SAVERR report programming.
  - Regional staff will be involved in decisions about reporting requirements.

- Moving forward with efforts to enhance the integration of additional data sources for electronic verification of client data (Data Broker).
  - Progress is being made with regard to streamlining access to child support data.
  - Evaluation is underway for incorporating other sources such as Systematic Alien Verification for Entitlements (SAVE) data, Bureau of Vital Statistics (BVS) data, and others.

- Providing training to program specialists in case reading, conducting office reviews, and providing effective feedback.
  - Program specialists will be assisting with mentoring, readiness preparation for TIERS rollout, office reviews, and improvement initiatives.

## Local Office Business Process

**Major Accomplishments:**

- Gathered data from eight offices over a two month period on why clients come into the office to target efforts for process improvements.
  - Sampled a mix of small and large offices, rural and urban, TIERS and SAVERR.
  - Data varies somewhat depending on the time of the month and the geographic location of the offices.
  - Approximately 4,875 clients came into the office for reasons other than scheduled appointments or dropping off applications.
  - Typically the most common reasons to come into an office include: dropping off an application, coming for an interview, dropping off verifications, obtaining a Medicaid card, completing EBT or finger-imaging, or getting policy questions answered.

- Process changes such as the implementation of "duty workers" and "lobby managers" are designed to address many of these client needs more efficiently.

- Beginning in June 2010, restructured local office processes by shifting expertise to the front-desk or lobby in many offices.
  - Implemented "Duty Workers" in 92 local offices. This includes all large, high traffic offices and others as beneficial. Duty workers are Texas Works Advisors who are stationed in the lobby to respond immediately to client needs that require a worker to perform the task (e.g., accepting verifications, processing changes, providing temporary Medicaid cards, and answering questions about the eligibility process).
  - Implemented "Lobby Managers" in medium to large offices, as appropriate. These are typically clerks who are stationed in the lobby to facilitate traffic flow, accept and review dropped off applications and verifications, assist clients in filling out forms, and address client questions quickly.
  - In August 2010, provided job aids to staff to clarify roles and responsibilities of duty workers and lobby managers.
  - The effectiveness of this project will be measured through customer service monitoring surveys that will be conducted by Texas Works supervisors in other offices. Approximately 500 surveys will be conducted each quarter, increasing the visibility of issues and facilitating problem resolution and process improvement.
  - Initial customer service monitoring results are expected in mid-October, 2010.

- Implemented "Same Day/Next Day" processes in which clients who walk in a local office to apply for assistance are interviewed the same day or the following day.
  - Currently, 207 offices have implemented this process statewide.
  - HHSC believes this has contributed to the significant improvement in timeliness and office lead times seen over the last 12 months.

- On March 1, 2010, implemented a pilot project in partnership with the Texas Food Bank Network to utilize community based organizations for SNAP application assistance, including conducting initial interviews.
  - One of the few pilots of this type in the nation.
  - Coordinating with food banks in Houston, San Antonio, Dallas and Fort Worth.
  - As of August 30, 2010, these community partners had conducted 9,076 interviews.
  - HHSC continues to monitor this project daily, and will be adding functionality into TIERS in April to improve the reporting and monitoring process for community based organizations.
  - To bolster the success of the project, staff work with the Texas Food Bank Network on timely submission of cases, documentation and data reconciliation.

**Additional Local Office Business Process Projects Underway:**

- Evaluation of the eligibility business process is ongoing.
  - Consideration is being given to models in other states.
  - Analysis of centralized functions is underway.

- Application registration and scheduling functions will be resumed by state staff at the local office level beginning January 1, 2011.

- Piloting projects to purge old paper SAVERR case files from 40 priority offices in Regions 3 and 6, following the agency's records retention schedule.
    - Have completed 11 offices; now concurrently working in eight offices (four in both regions 3 and 6).
    - Expect to complete purging all 40 offices by December 2010.

- Preparing SAVERR imaging pilot project to improve staff access to documents.
    - Contract has been negotiated and is being reviewed.
    - Intend to pilot SAVERR imaging in four local eligibility offices in Region 3.
    - Imaging will not be in MaxieIE, this will be a separate content manager and repository.

- Researching statewide and long-term alternatives for imaging.
    - An enhanced statement of work for a statewide 1.9 million dollar SAVERR imaging contract has been drafted and is under review.
    - Staff are also researching long-term imaging alternatives that would leverage in-house resources such as the Xerox multi-purpose machines.

- Developing a plan to increase the use of community and faith-based volunteers in providing assistance to local offices.
    - Plan to track and expand the use of volunteers from Workforce Board contractors.

**Process and System Integrity**

**Major Accomplishments:**

- Reduced maximum time to authorize new user access for Outlook/LAN use and TIERS by nearly half (Outlook/LAN from 9 days to 5 days, TIERS from 5 days to 3 days).
    - In August, the average number of business days to provision new users for Outlook/LAN was 3.13 days; the average number of days to provision for TIERS was 2.39 days.
    - All students in TIERS classes are provisioned before returning to their office.
    - HHSC is evaluating additional automation to further reduce time for TEIRS provisioning.

- Completed a comprehensive review of documentation requirements for eligibility determinations (addresses single statewide audit finding).
    - Providing clarification and training to staff and updating the worker handbook to reduce any unnecessary documentation being done in TIERS case comments (October 1, 2010).
    - In June, required that all staff with record management responsibilities review policies and procedures related to document  to check for the availability of appropriate verification documents in case files.

- Have planned modifications to Management Evaluation and Quality Control procedures to check for appropriate verification documents in case files beginning with the new Federal Fiscal Year.

- Implemented procedures to ensure that TANF sanctions are imposed as soon as possible (addresses single statewide audit finding).
  - In TIERS, most OAG and TWC sanctions are applied via automated interface.
  - In a limited number of situations, these sanction requests "exception out" of the automated process. This happens when eligibility staff are working on the case to process a review or a change. (Often these cases are pended for verifications.)
  - HHSC has implemented a process whereby CCC staff review individual cases on daily exception reports and prompt the appropriate staff to take action if all information needed to complete the case action has been received, thereby allowing the sanction to be processed.
    - The impact of this process will be evaluated in the spring when additional regions have converted to TIERS and several months' data can be collected based on improved timeliness and the centralization of this function.
  - HHSC also has begun conducting semi-annual reviews of requests for sanction from TWC to identify and resolve any timeliness issues.
    - The first review, using May 2010 data, indicated that 8.52% of records were sent 8 days or more after the non-cooperation determination. HHSC is working with TWC liaisons to resolve the issues.
    - Another review will be completed using October data to ensure the issue is being resolved.

**Additional Process and System Integrity Projects Underway:**

- Developing processes to strengthen fraud detection and prevention through coordination between eligibility services and the Office of the Inspector General (SAO finding).

- Strengthening Electronic Benefit Transfer (EBT) security policies and procedures (addresses single statewide audit finding).
  - Reviewing policies and procedures about maintenance of records, cards and PINs with EBT staff statewide.
  - Expanding the scope of regional reviews to include additional reconciliation reports, voided logs, mail logs, and card/pin security.
  - Requesting Internal Audit review of existing EBT policies and procedures.
  - Evaluating policies and procedures regarding when EBT cards are mailed, rather than provided at the local office.

**Next Steps:**

Executive management of HHSC continues to regularly monitor projects under the Comprehensive Management Improvement Plan. Feedback on our progress will be provided to the Governor's office, as well as to the State Auditor's Office and federal partners.

Interim Charge #4: *Study and make recommendations on the state's role for facilitating the exchange of health care information in the future, including using the Medicaid exchange as a framework for the statewide exchange of health information between health care providers to improve quality of care; what information the state would provide; how to use this information to improve care management, prevent medical errors, and reduce unnecessary services; and policies and statutory changes needed to ensure that privacy is protected. Study the feasibility of developing multiple regional health information technology exchanges in Texas.*

# Section I. Background

A number of industries have used information technology (IT) to improve business processes, leading to increased efficiency and reduced costs. However, the health care industry has lagged behind in its adoption of IT, despite some estimates that nearly a third of all health care costs result from administrative inefficiency, unnecessary treatment, medical errors, and other waste.[1]

Numerous health IT tools are already available to health care providers and have the potential to vastly improve health care quality, efficiency, and safety. Common examples of health IT tools include electronic health records, personal health records, electronic prescribing (e-prescribing), home monitoring systems, and clinical decision support systems.[2]

While quality and efficiency gains can be made through the use of health IT within a single practice or health care facility, the true benefits of health IT are realized when the various providers caring for a patient are able to share patient health information, commonly referred to as health information exchange (HIE). HIE brings together patient medical records, which are currently fragmented among a patient's providers, in the form of an electronic health record (EHR). EHRs allow health care providers to access timely and comprehensive patient medical information, regardless of which provider rendered the services.

Texas policymakers, who have long realized the benefits of HIE, have used previous legislative sessions to establish a framework to promote and coordinate the exchange of health information in Texas. The federal government has also invested billions of dollars through the American Recovery and Reinvestment Act (ARRA) to increase EHR adoption by providers and help states build the infrastructure necessary to support statewide HIE.

As the state moves forward with developing a statewide infrastructure to support HIE, Texas policymakers will need to determine what role the state should play in facilitating this process and ensuring that the medical privacy of Texans is protected.

# Section II. Analysis

Recognizing the potential for HIE to vastly improve the health care delivery system, a number of local, state, and federal HIE efforts are currently underway. This section discusses these efforts and identifies opportunities for the state to help facilitate the implementation of a statewide HIE infrastructure.

## Texas Health Information Exchange Framework

Historically, Texas health IT policy has centered on several overarching principles:

- ***Focus on patients and consumers:*** Privacy and patient control over health information should be protected.
- ***Utilize market-based solutions:*** The government should play a limited role, primarily catalyzing and facilitating health IT.
- ***Leverage existing resources:*** The state should leverage existing resources and coordinate with existing health IT initiatives to the maximum extent possible.
- ***Allow for local control and solutions:*** A state as diverse as Texas requires that each region have the freedom to determine how best to fit into the state health IT infrastructure.[3]

In line with these principles, in 2007 the Legislature established the Texas Health Services Authority (THSA), structured as a public non-profit cooperation, to promote, implement, and facilitate the exchange of health information in Texas.[4]

**THSA Mission**

*The Texas Health Services Authority will promote and coordinate the development of a seamless electronic health information infrastructure to improve the quality, safety, and efficiency of the Texas health care sector while protecting individual privacy.*[5]

THSA is governed by a board appointed by the Governor and approved by the Senate.[6] Members of the THSA board represent the various groups that participate in HIE: consumers, clinical laboratories, health insurers, hospitals, regional HIE networks, pharmacies, physicians, and other health care providers.[7] To ensure coordination with other state health IT and HIE initiatives, the board also includes ex-officio members from the Department of State Health Services (DSHS), and works closely with the Office of e-Health Coordination at the Health and Human Services Commission (HHSC).

To date, THSA has not received state funding. However, in coordination with HHSC, THSA has received federal funding under the State HIE Cooperative Agreement Program to plan and implement a statewide HIE infrastructure for Texas. For a discussion of the State HIE Cooperative Agreement Program and THSA's activities since receiving this federal funding, see the section on "Statewide Health Information Exchange."

### *Texas Medicaid HIE Initiatives*

Texas is in the process of implementing two HIE initiatives within the Medicaid program. Policies developed and lessons learned during these two initiatives can help shape broader statewide HIE.

In 2009, the Texas Legislature directed HHSC to establish an HIE infrastructure for Medicaid and Children's Health Insurance Program (CHIP) to improve the quality, safety, and efficiency of health care services provided under these programs. This infrastructure will supplement the information providers have within their own offices with information from Medicaid and CHIP claims, encounters, vendor drug data, and immunization history, giving providers a more

comprehensive medical history for their Medicaid and CHIP patients. This project is targeted for full implementation in June 2011.[8]

In 2009, the Legislature also directed HHSC to establish a pilot project to determine the feasibility, costs, and benefits of exchanging secure electronic health information between HHSC and local/regional HIE networks. A local/regional HIE network, also referred to as a regional health information organization (RHIO), exchanges health information among health care providers within a defined geographic area to improve health care in that community.[9] HHSC has identified potential HIE organizations and plans to begin the pilot in December 2010.[10]

## Statewide Health Information Exchange

As mentioned previously, the federal government is investing billions of dollars to facilitate the exchange of health information through several programs created by the American Recovery and Reinvestment Act (ARRA). The focus of these programs is not to adopt technology for technology's sake, but rather to use the technology in a way that improves patient care and health care efficiency, referred to as "meaningful use."

### *Incentive Programs*

Under the Medicare and Medicaid EHR incentive programs, the Centers for Medicare and Medicaid Services (CMS) will provide incentive payments beginning in 2011 to eligible Medicaid and Medicare health care providers who adopt a certified EHR and demonstrate "meaningful use."[11]

As much as $27 billion in incentive payments may be distributed to providers nationally over ten years. To receive incentive payments, eligible health care professionals must choose to participate in the Medicare or Medicaid incentive program and may receive as much as $44,000 under Medicare or $63,750 under Medicaid. Eligible hospitals can participate in both programs and may receive millions of dollars through Medicare and Medicaid.[12] In 2015, eligible providers that fail to demonstrate meaningful use of certified EHR technology will have their Medicare payments reduced.[13] The federal legislation did not include corresponding Medicaid reimbursement penalties.

To help health care providers adopt and become meaningful users of EHRs, the federal legislation also included funding for Regional Extension Centers (RECs) around the country to provide education, outreach, and support to primary care providers. Texas received funding to establish four RECs:[14]

- CentrEast Regional Extension Center (through the Rural and Community Health Institute, Texas A&M University Health Science Center)
- Gulf Coast Regional Extension Center (through the School of Biomedical Informatics, University of Texas Health Science Center at Houston)
- North Texas Regional Extension Center (through the Dallas-Fort Worth Hospital Council Education and Research Foundation)
- West Texas Regional Extension Center (through the Institute for Rural and Community Health, Texas Tech University Health Sciences Center)

One of the first requirements of "meaningful use" is the capability to electronically exchange health information. To help states build the HIE infrastructure needed for providers to meet these requirements and avoid Medicare penalties beginning in 2015, ARRA also included funding under the State Health Information Exchange Cooperative Agreement Program.

***State Health Information Exchange Cooperative Agreement Program***

The State Health Information Exchange Cooperative Agreement Program provides funding to states for the planning and implementation of a statewide HIE infrastructure to improve health care quality, safety, and efficiency. In October 2009, HHSC submitted Texas' application, which specified that HHSC would serve as the fiscal agent and would contract with THSA to develop the required strategic and operational plans through an open and participatory planning process.[15]

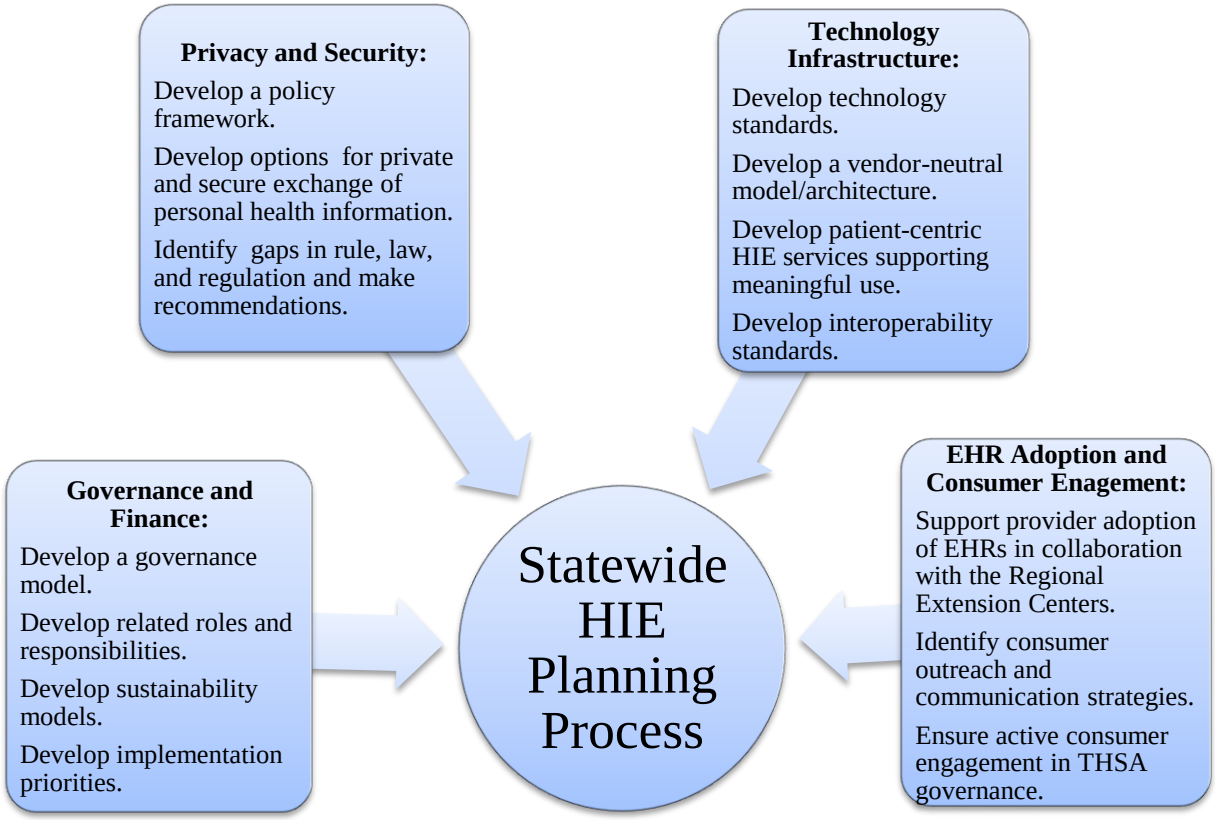
In March 2010, the Office of the National Coordinator for Health Information Technology (ONC) awarded HHSC $28.8 million over four years. Of this allotment, Texas used $1 million to develop the required strategic and operational plans. Access to the remaining $27.8 million for HIE implementation was made contingent on ONC's approval of those plans.[16]

Over the course of 2010, THSA engaged in an extensive planning process. To ensure public input in the development of the plans, THSA established four workgroups:[17]

- Governance and Finance
- Privacy and Security
- Technology Infrastructure
- EHR Adoption and Consumer Engagement

Since January, the workgroups, which consisted of over 160 stakeholders from different disciplines, have held over 22 meetings and webinars. Eight public meetings were held in Austin, four in Dallas, four in San Antonio, and four in Lubbock.[18] Figure 1 outlines the tasks asked of each workgroup.[19]

**Figure 1. THSA Workgroups**




THSA held public meetings in April, June, July, and August to review the policy options developed by the workgroups and to provide comments and direction before submission of the strategic and operational plans to ONC.[20] THSA received letters of support for its plans from a broad range of groups including the Texas Association of Health Plans, Texas Council of Community Centers, Texas e-Health Alliance, Texas Hospital Association, Texas Medical Association, Texas Health Information Exchange Coalition, and all four Texas Regional Extension Centers.[21]

On September 10, 2010, HHSC submitted Texas' plans to ONC. On November 12, 2010, HHSC received federal approval of its plans, releasing the state's $27.8 million allotment for implementation.

Overview: Texas Strategic and Operational Plans

The overarching goal of Texas' HIE strategic and operational plans is to enable improvements in the quality, safety, and efficiency of the Texas health care sector by establishing a state HIE infrastructure that supports private, secure, and reliable HIE services to all Texas patients and health care providers.[22]

Acknowledging that local HIE activity is already underway in many parts of the state, THSA plans to use local HIE networks as the base for the statewide HIE infrastructure. This approach allows buy-in and sustainability to be generated locally and ensures HIE services for the entire state so that all Texas providers can meet federal "meaningful use" requirements.[23]

THSA plans to use three strategies to implement this approach:[24]

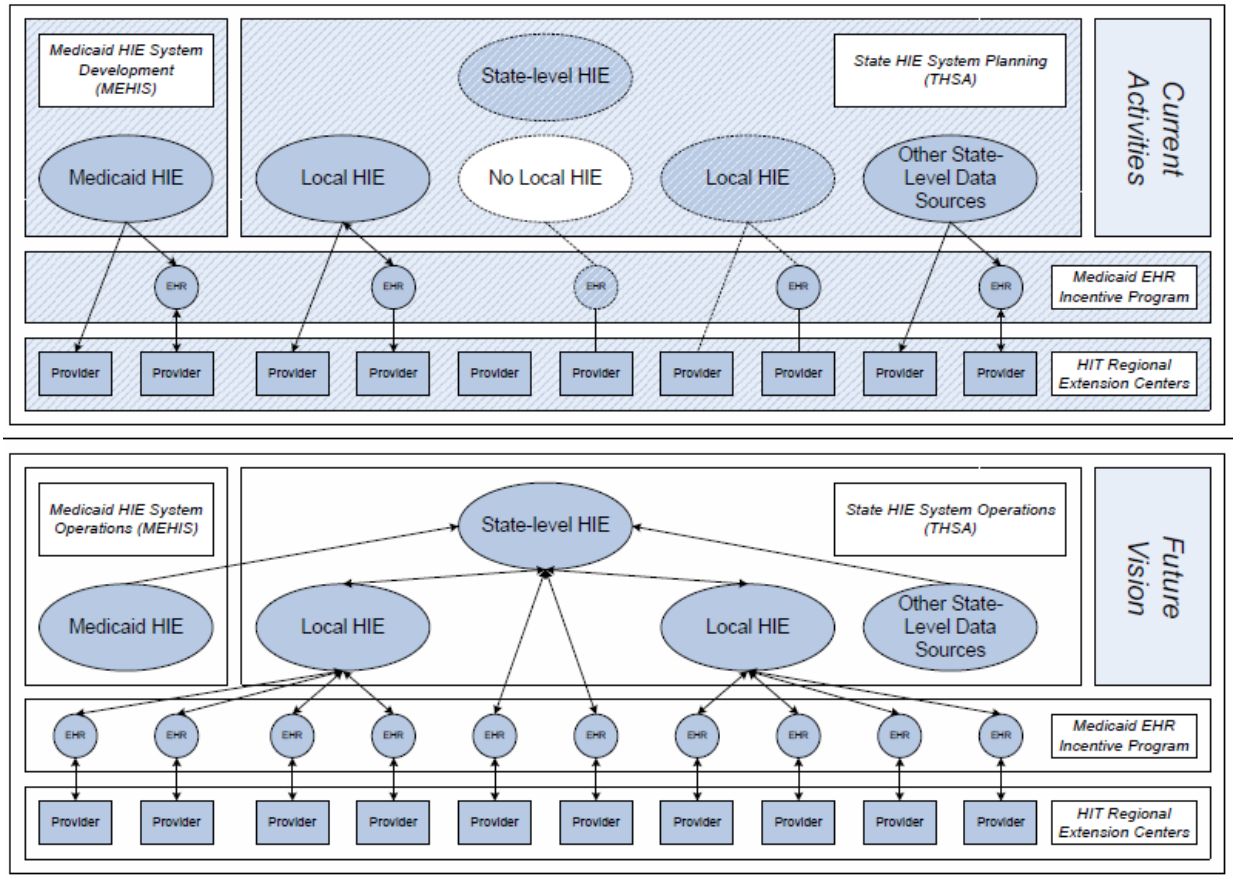
- *General State-Level Operations*
  Although the delivery of HIE services will primarily occur at the local level, THSA will provide oversight and accountability through statewide standards, operational requirements, and performance and accountability measures to ensure that HIE around the state is coordinated.

- *Local HIE Grant Program*
  Because existing local HIE networks in Texas are in varying stages of implementation and functionality, THSA plans to develop a grant program that will help upgrade existing local HIEs and develop new ones in areas where an HIE does not already exist. The local HIEs will be required to meet the statewide standards established by THSA. When feasible, THSA should leverage existing state infrastructure and contracts to help these local HIE networks achieve greater economies of scale.

- *White Space Coverage*
  THSA recognizes that not every provider will be affiliated with a local HIE network. To fill in these gaps, THSA plans to contract with one or more entities to provide HIE connectivity to areas of the state without local HIEs (referred to as the "white space").

This "network of networks" approach will link local HIE networks together, link local HIE networks to state agencies, and ultimately link statewide networks to each other and to the National Health Information Network (NHIN).[25] Figure 2 compares the current state of HIE in Texas to the future Texas HIE infrastructure as envisioned by the strategic and operational plans.[26]

**Figure 2. State-Level HIT and HIE Planning and Development in Texas**




Moving forward, HHSC will continue to serve as the fiscal agent for the federal program. Federal funding is expected to fund THSA's HIE implementation activities through 2013. Using experiences and data from HIE operations in 2012, THSA plans to develop a sustainability model that does not rely on federal or state funding to support the statewide HIE infrastructure once federal ARRA funding discontinues. Table 1 outlines HIE activities planned for years 2011-2013.[27]

**Table 1. HIE Activities (2011-2013)**

| Year | HIE Activities |
|---|---|
| 2011 | • THSA will award local HIE grants for planning and development.<br>• THSA will evaluate proposals and execute white-space contract(s). |
| 2012 | • THSA will develop, implement, and operate shared state-level services.<br>• Local HIEs will be fully operational.<br>• White-space coverage will be fully operational. |
| 2013 | • Evaluation of HIE operations.<br>• Sustainability dialogue and development of sustainability model.<br>• Transition to sustainability. |

THSA will continue to be responsible for maintaining consumer engagement and working with the Legislature on policy development for finance, technical infrastructure, HIE business operations, and privacy and security.

***Remaining HIE Issues***

As implementation of a statewide HIE infrastructure moves forward, THSA and state policymakers will have to grapple with a number of challenges:

Health Information Privacy

Research on consumer attitudes towards health IT consistently indicates that there is significant public support for health IT. However, the public is concerned about whether their health information will be sufficiently protected in the emerging electronic environment.[28]

Medical records include highly sensitive information, and the misuse of this information can lead to not only financial, but also personal, consequences for patients. The ability of HIE to significantly improve health care quality and efficiency will depend heavily on patients' confidence that their health information is secure. Patient distrust can lead to the omission of critical health information, leading to potentially dangerous results.

In response to health information privacy concerns, ARRA included a number of expansions, under the Health Information Technology for Economic and Clinical Health (HITECH) Act, to existing federal health information privacy protections. For example, HITECH:

- allows individuals to choose to withhold health information related to services they paid for personally;
- requires individuals to be notified of any security breaches involving their health information;
- subjects individuals who knowingly access, use, or disclose personal health information (PHI) for improper purposes to criminal penalties;
- prohibits the sale of PHI without the patient's consent; and
- explicitly extends existing federal health information privacy law to health information exchanges.[29]

These federal requirements serve as a baseline, and states can choose to provide additional protections to its residents. For example, states can choose to enhance these federal protections and increase the available penalties under state law. In addition, existing Texas statutes pertaining to theft were written prior to the widespread use of EHRs and HIE and do not adequately address crimes related to PHI, such as medical identity theft and breach of computer security involving PHI. Many times, punishment for these offenses depends on the value of the item stolen. Because it is difficult to quantify the value of PHI, state statute will need to be updated to adequately punish crimes involving PHI. State policymakers may also want to consider strengthening existing privacy protections for health information currently collected and maintained within state agencies. For example, contracts between agencies and any contractors that may have access to PHI in the course of their work could be required to include confidentiality and data use requirements to ensure that PHI is properly protected.

Legislators should also work to empower consumers by supporting greater patient control over PHI and providing educational resources about their privacy rights. One such resource could be a website informing consumers of their rights in relation to PHI, including contact information for filing complaints with appropriate licensing boards and agencies. Because the state's current

legal framework was developed primarily for a paper-based environment, policymakers should also ensure that patients have explicit right to their electronic health data.

As the adoption of EHRs and implementation of statewide HIE progress, the state's privacy and security policies will need to continue to evolve. THSA's Privacy and Security workgroup will play an important role in this process, providing guidance on how to ensure that HIE in Texas is secure, protects patient privacy, and supports greater access by and control over personal health information by patients.

Provider Adoption

Federal and state efforts to implement a statewide HIE infrastructure will not achieve increased health care quality and efficiency without widespread adoption of EHRs.

Over the last few years, studies of EHR adoption rates indicate an upward trend.[30] However, a survey of physicians in 2009 indicated that 27 percent of physicians still have no plans to adopt an EHR system. The survey also indicated that only 4 percent of physicians already using an EHR have fully functional systems.[31]

The biggest barrier to EHR adoption cited by physicians is the belief that the costs of EHR adoption outweigh the benefits.[32] This is, at least in part, due to the current fee-for-service reimbursement structure. When providers implement health IT, patients benefit from better care and payors benefit from decreased costs due to reductions in duplicative tests and medical errors. Meanwhile, health care providers bear the costs of implementing the technology and may earn lower revenues due to increased efficiency and quality. To achieve widespread health IT adoption, the payment structure will need to reward, not penalize, providers for increases in quality and efficiency.

State-Level Data Sources

The future Texas HIE infrastructure as outlined by THSA envisions the incorporation of information from the Medicaid/CHIP HIE (currently in development) and other state-level data sources. Policymakers will need to review existing state-level databases and determine which systems have the potential to enhance health care quality in Texas by making health information available to providers that supports their delivery of care. Legislators may need to address statutory barriers that currently prevent this information from being shared securely.

E-prescribing

E-prescribing is the electronic transfer of prescription-related data among prescribers, pharmacies, and payors. Prescription-related data can include new prescriptions, prescription changes or cancellation, refill requests, prescription fill status, and patient medication history. E-prescribing increases efficiency and also reduces some of the patient safety risks associated with prescribing such as illegible handwriting and limited information about a patient's medication history. [33]

While e-prescribing use among physicians in Texas increased to 15 percent in 2009, a 375 percent increase from 2007, [34] several barriers to the widespread utilization of e-prescribing still exist:

- Federal CMS rules require a prescriber to handwrite a message for Medicaid prescriptions when the brand drug should be dispensed instead of the generic.[35]
- Pharmacy acceptance of e-prescribing in Texas, especially among independent pharmacies, is still limited.[36]
- Until recently, the federal Drug Enforcement Agency (DEA) prohibited the e-prescribing of controlled substances. The DEA recently revised its rules to allow e-prescribing for these medications as long as the prescriber meets certain authentication (security) requirements. However, Texas law still requires prescriptions for Schedule II controlled substances to be written on an official form issued by the Texas Department of Public Safety (DPS).[37] This requirement is part of the Texas Prescription Program and is intended to ensure these drugs are not abused. As more providers utilize e-prescribing, policymakers may want to determine whether there are ways to eliminate this barrier to e-prescribing while still supporting state law enforcement policy goals.

Like other health IT tools, the benefits to e-prescribing are only realized with widespread adoption and participation. To achieve greater e-prescribing participation in Texas, relevant state agencies, health care providers, and pharmacies should work together to resolve remaining challenges related to e-prescribing.

Medical Liability

Although one of the primary goals of EHRs and HIE is to reduce the occurrence of medical errors, the use of these technologies raises several questions related to medical liability:

- What happens when a provider relies on electronic data received from another provider that is incorrect or corrupted?
- EHRs are living documents that change in real-time. If a medical liability issue arises, how does a provider prove what information was available to them at the time of treatment?
- How much of the newly available medical information will providers be responsible for reviewing?

These concerns highlight gaps in existing statute and case law. To achieve widespread adoption of EHRs by providers, the state will likely need to clarify medical liability as it relates to EHRs and HIE.

# Section III. Conclusion

Over the past several sessions, the Texas Legislature has established a framework for HIE in Texas to improve health care quality, safety, and efficiency. Created by the Legislature with the intent of coordinating and promoting HIE for Texas, THSA, in coordination HHSC, is utilizing federal funding to plan and implement a statewide HIE infrastructure for the state of Texas. Moving forward, THSA and policymakers will need to work together to facilitate the secure exchange of health information within the emerging HIE infrastructure.

# Section IV. Recommendations

1. **The Texas Legislature should work with the Texas Health Services Authority to move forward with implementation of a statewide health information exchange infrastructure.**

2. **The Texas Health Services Authority should leverage existing state infrastructure when possible to take advantage of economies of scale.**

3. **The Texas Health Services Authority and the Texas Legislature should work together to ensure that the exchange of health information is secure and patient privacy is protected.**

4. **Patients should have explicit right to their electronic health data.**

5. **Health care providers, relevant state agencies, and pharmacies should work together to resolve remaining challenges related to e-prescribing.**

---

[1] Kelley, Robert. "Where Can $700 Billion in Waste be Cut Annually from the U.S. Healthcare System?" Thomson Reuters, October 2009, p24.
[2] Dr. Charles Bell, Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services*, p3, (Austin, TX, April 15, 2010).
[3] Texas Health Services Authority, *The State of Health IT in Texas 2009*, March 2009, p12.
[4] House Bill 1066, 80th Regular Session, 2007 (Delisi/Nelson).
[5] Texas Health Services Authority. (2010). *Mission*. Available: http://www.thsa.org/, Accessed: November 11, 2010.
[6] Texas Health Services Authority, *2009 Annual Report*.
[7] Texas Health Services Authority, *State of Texas Strategic and Operational Plans for Statewide Health Information Exchange*, September 8, 2010, p4.
[8] Information provided by Health and Human Services Commission staff, November 9, 2010.
[9] Dr. Charles Bell, *supra* note 2 at p4.
[10] Health and Human Services Commission staff, *supra* note 8.
[11]U.S. Department of Health and Human Services. (2010). *Overview: EHR Incentive Program*. Available: https://www.cms.gov/EHRIncentivePrograms/, Accessed: November 9, 2010.
[12]U.S. Department of Health and Human Services, "Secretary Sebelius Announces Final Rules to Support 'Meaningful Use' of Electronic Health Records," July 13, 2010, Available: http://www.hhs.gov/news/press/2010 pres/07/20100713a.html, Accessed November 9, 2010.
[13] *Id.*
[14] Texas Regional Extension Centers. *Texas RECs.* Available: http://www.txrecs.org/, Accessed: November 9, 2010.
[15] Texas Health Services Authority, *supra* note 6.
[16] Manfred Sternberg, Texas Health Services Authority, *Testimony before the Senate Committee on Health and Human Services*, p5, (Austin, TX, April 15, 2010).
[17] Texas Health Services Authority, *supra* note 7 at p10.
[18] *Id.*
[19] *Id.* at p11.
[20] *Id.*
[21] *Id.* at Appendix J.
[22] *Id.* at p3.
[23] *Id.* at p5.

[24] Texas Health Services Authority, *Briefing to Legislative Staff,* "Health Information Exchange Statewide Planning Process," p13, (Austin, TX, August 24, 2010).
[25] Texas Health Services Authority, *supra* note 7 at p5.
[26] *Id.* at p6.
[27] Texas Health Services Authority, *supra* note 24 at p19.
[28] Texas Health Services Authority, *supra* note 3 at p8-10.
[29] Nora Belcher, *Testimony before the Senate Committee on Health and Human Services,* p3-5, (Austin, TX, April 15, 2010).
[30] Texas Health Services Authority, *supra* note 7 at p34.
[31] Dr. Joseph H. Schneider, *Testimony before the Senate Committee on Health and Human Services,* p20-21, (Austin, TX, April 15, 2010).
[32]*Id.* at p20-22.
[33]Health and Human Services Commission, *Electronic Prescribing Implementation Plan*, December 1, 2009, p3-4.
[34] Texas Health Services Authority, *supra* note 7 at p28.
[35] Dr. Joseph H. Schneider, *supra* note 31 at p6.
[36] *Id.*
[37]Texas Department of Public Safety. *The Prescription Forms.* Available: http://www.txdps.state.tx.us/RegulatoryServices/prescription_program/prescriptionforms.htm, Accessed: November 9, 2010.

Interim Charge #5: *Study the state's current and long-range need for physicians, nurses, dentists and other allied health and long-term care professionals. Provide recommendations for ensuring sufficient numbers of health care professionals, focusing on medically underserved and rural areas of the state as well as the border region. Consider health care delivered by Advanced Practice Nurses in terms of access, cost and patient safety and include an assessment of independent prescriptive authority with those states in which prescriptive authority is delegated by a physician. Make recommendations to enhance the efficient use of Advanced Practice Nurses in Texas.*

# Section I. Background

For years, Texas' health care delivery system has struggled to keep pace with the state's changing demographics. Demographic projections presented to the Senate Committee on Health and Human Services this interim predicted a grim future for the state's health care system unless action is taken to address the existing health care workforce shortages and prepare for future challenges.

## Health Care Needs

Texas' population continues to grow rapidly, with an estimated growth of 3.9 million between 2000 and 2009. Using recent population growth trends, Dr. Karl Eschbach, former State Demographer, estimates that the state's population could reach 44.9 million by 2040, compared to 24.8 million in 2009.[1]

Like the rest of the country, Texas' population continues to age. According to Dr. Eschbach's projections, the state's 65-and-older age group could double, and possibly triple, in size between 2010 and 2040. By 2040, this group is estimated to account for nearly one-fifth of the state's total population, compared to approximately one-tenth of the current population.[2] A majority of this population suffers from at least one chronic condition, and many from multiple conditions. In 2002, more than half of Medicare[3] enrollees received treatment for at least five chronic conditions.[4] A large proportion of the elderly population also requires some long-term care services and supports. As baby boomers reach retirement age and life expectancy increases, the state's health care system will be challenged to meet the health needs of this population.

Chronic diseases are not only common among the elderly; they are becoming increasingly prevalent among the general population. This proliferation of chronic conditions, many of which are preventable, has contributed to the current strain on the state's health care workforce by increasing the demand for services. A number of chronic conditions stem from obesity. Data projections from the Texas State Data Center estimate that the number of obese adults in Texas will reach crisis levels by 2040, increasing from 5.3 million in 2010 to nearly 15 million, approximately one-third of the projected total population in 2040. According to Dr. Eschbach, this is a conservative estimate; the actual number may be much higher, closer to 40-50 percent of the population. The Data Center also predicts that by 2040, a quarter of Texas adults will have diagnosed diabetes.[5] Witnesses testifying at the Committee's hearing on February 23rd emphasized primary preventative care as the key to heading off the state's chronic disease crisis.

In March, President Barack Obama signed the *Patient Protection and Affordable Care Act*, more commonly referred to as "federal health care reform," into law. In an effort to increase health insurance coverage in the U.S., the new law expands Medicaid eligibility, provides subsidies to help families purchase private health insurance, and mandates individuals to purchase health

insurance and employers to offer it. During the April 22nd hearing of the House Select Committee on Federal Legislation, the Health and Human Services Commission (HHSC) estimated that the uninsured population in Texas will drop from 6.5 million to 2.3 million under the new law, with roughly 2 million of these individuals moving into the Medicaid program.[6]

As more Texans enter the private health insurance market or Medicaid, the demand for primary care providers and specialists will increase as individuals who have typically delayed care or sought treatment in the emergency room will try to access health care providers under their new health insurance coverage. How successful the newly and previously insured are in accessing health care will depend largely on how the state addresses its workforce shortage.

## Health Professionals Supply

Like the demographics of the general population discussed previously, characteristics of the health care workforce also contribute to the state's current health care workforce shortage.

As Texans age, so do their health care providers. The proportion of physicians at or nearing retirement age is growing. Between 2004 and 2009, the percentage of physicians under 55 decreased, while the percentage of physicians 55 and older increased. Table 1 provides a detailed breakdown of changes in physician population age.[7] This trend is common among other health professions as well. For example, the average age of a nurse in Texas is 46.[8]

**Table 1. Changing Demographics of the Physician Population (by Age)**

| | 2004 | | 2009 | |
|---|---|---|---|---|
| **Age** | **Number** | **Percent** | **Number** | **Percent** |
| 25 to 34 | 2,641 | 7.6 | 2,405 | 6.1 |
| 35 to 44 | 10,736 | 30.7 | 11,382 | 28.9 |
| 45 to 54 | 11,048 | 31.6 | 11,780 | 29.9 |
| 55 to 64 | 7,030 | 20.1 | 9,068 | 23.0 |
| 65 to 74 | 2,637 | 7.5 | 3,610 | 9.2 |
| 75 or older | 840 | 2.4 | 1,126 | 2.9 |
| Total | 34,932 | 100.0 | 39,371 | 100.0 |

Another notable characteristic of the health professions workforce is that it is not distributed across the state in proportion with the general population. Over the past several decades, a number of geographical trends in the supply of health professionals in Texas have emerged:

- Metropolitan (urban) counties have higher health professional supply ratios (health professionals per 100,000 people) than non-metropolitan (rural) counties.
- Non-border counties have higher health professional supply ratios than border counties.
- The Panhandle, West Texas, and South Texas typically have lower health professional supply ratios than the rest of the state.
- The largest growth in supply of health professionals has been in Central, East, and Northeast Texas.[9]

As discussed earlier, the state faces a health care crisis unless action is taken to decrease the prevalence of preventable chronic conditions. However, the growth of primary care physicians,

who would provide a bulk of the care needed to prevent and address chronic conditions, is not keeping up with population growth.

As health care providers deal with changes made by federal health reform legislation, uncertainty about Medicare reimbursement rates for physicians, and looming state Medicaid provider rate cuts, currently underserved populations will almost certainly face greater challenges accessing health care in the near future.

# Section II. Analysis

As these data and projections suggest, the state faces many challenges related to its health care workforce. This section examines these challenges in further detail.

## Challenge 1: Access to Care

Health professional supply data in Texas indicate that many Texans have inadequate access to health care. The federal Health Professional Shortage Area (HPSA) designation identifies areas with an inadequate supply of health care providers. There are three types of HPSA designations: primary care, dental, and mental health. HPSAs can also fall into several categories: whole county, partial county (geographic sub-county area), and special population group (such as low income). In some cases, facilities may also be designated as a HPSA.[10] Nearly three-quarters of Texas counties are designated as HPSAs,[11] with the rural and border areas of the state experiencing more severe shortages than metropolitan and non-border areas.

More specifically, as of October 2009, out of Texas' 254 counties:

- 118 counties were designated as whole county primary care HPSAs;
- 71 counties were designated as partial county or low income primary care HPSAs;
- 173 counties were designated as whole county mental health HPSAs;
- 4 counties were designated as partial county or low income mental health HPSAs;
- 82 counties were designated as whole county dental HPSAs; and
- 29 counties were designated as partial county or low income dental HPSAs.[12]

Statewide, Texas health professional supply ratios generally lag behind U.S. ratios. Figures 1 and 2 specifically compare the physician and registered nurse supply ratios of Texas to those of the U.S.[13] This trend is also found among other health professionals such as physician assistants, chiropractors, podiatrists, nurse practitioners, certified nurse midwives, registered nurses, dentists, dental hygienists, physical therapists, and psychologists.[14] Supply ratios for the various state-licensed health professions in Texas are available on the Department of State Health Services' website at: www.dshs.state.tx.us/chs/hprc/health.shtm.

**Figure 1. Direct Care Physician Supply Ratio (U.S. and Texas)**

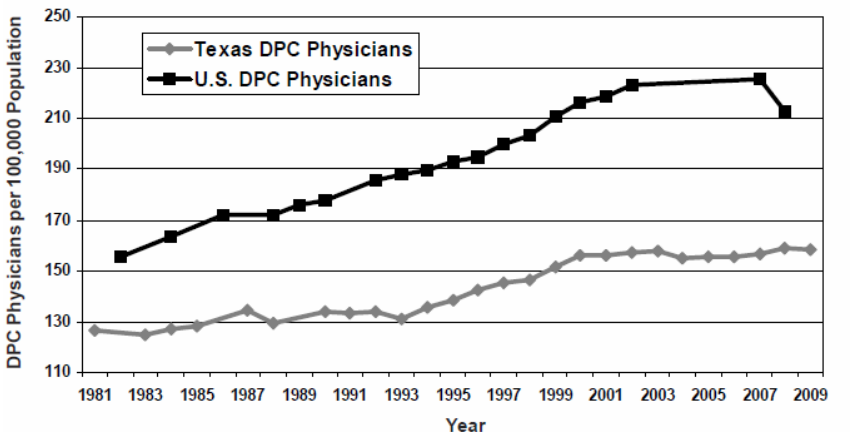
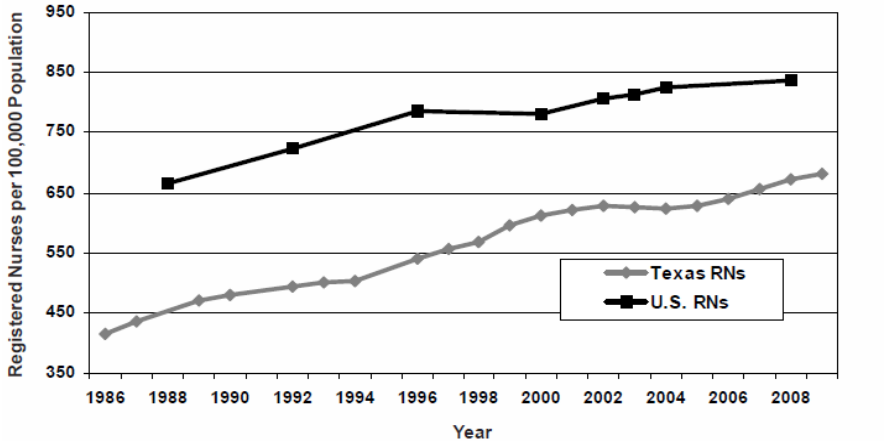



**Figure 2. Registered Nurse Supply Ratio (U.S. and Texas)**




## Access to Primary Care

One of the major areas in which Texas' health care workforce supply is falling behind is primary care. A strong primary care workforce can improve the quality and efficiency of the health care delivery system through health promotion, care coordination, disease prevention, patient education, and the diagnosis and treatment of chronic illnesses.[15] According to Johns Hopkins professor Dr. Barbara Starfield, primary care should provide:

- an accessible first contact for health care needs;
- person-focused care over the long-term;
- comprehensive care for common health care needs; and
- coordination of care with other components of the health care delivery system.[16]

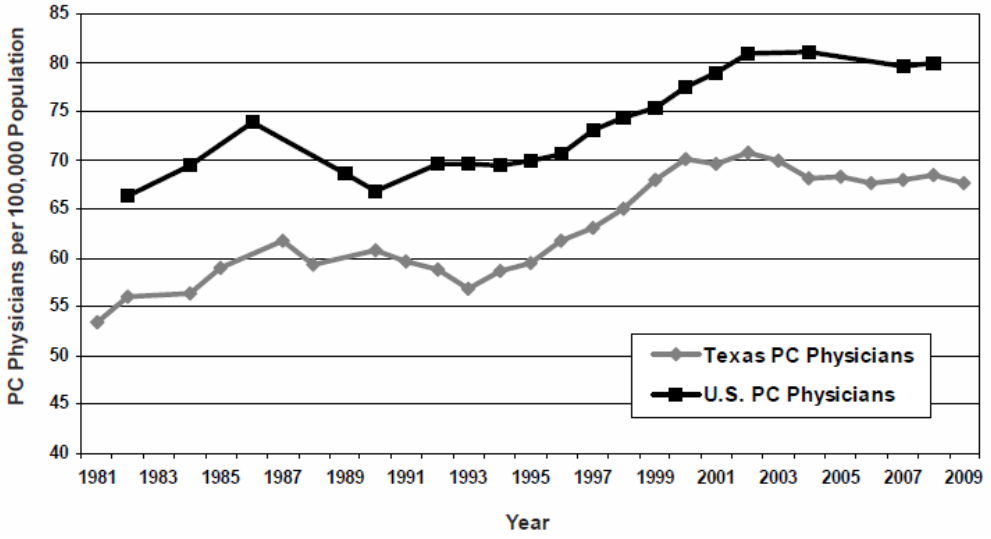
While Texas has made efforts to increase the supply of primary care practitioners, many challenges and gaps remain.

### *Primary Care Physicians*

Primary care physicians practice in family practice/medicine, general practice, general internal medicine, general pediatrics, obstetrics and/or gynecology, or geriatrics, and are typically viewed as the "gatekeepers" of the health care delivery system.[17]

A strong primary care physician workforce has been associated with higher quality of care, better patient outcomes, and greater efficiency within the health care delivery system. As Figure 3 indicates, Texas lags behind the rest of the country in supply of primary care physicians.[18]

**Figure 3. Primary Care Physicians Supply (U.S. versus Texas)**




The actual number of primary care physicians in Texas is increasing, but at a lower rate than the state's general population. In contrast, the supply of specialists is increasing faster than the general population. Table 2 compares the growth between 2004 and 2009 of primary care physicians, specialists, and the general population.[19]

**Table 2. Physicians in Direct Patient Care**

| Physicians in Direct Patient Care | 2004 | 2009 | Increase | Percent Increase |
|---|---|---|---|---|
| **Primary Care** | 15,374 | 16,830 | 1,456 | 9.6% |
| **Specialist** | 19,558 | 22,544 | 2,986 | 15.3% |
| **Total** | 34,932 | 39,374 | 4,442 | 12.7% |
| **Texas Population (millions)** | 22.4 | 24.8 | 2.4 | 10.5% |

Several factors drive this trend toward specialties and away from primary care:

**1. The current health care reimbursement system does not promote primary care.** The current reimbursement system compensates primary care physicians for office visits but not for preventive care, chronic illness management, or patient education. Innovative, less costly physician-patient interactions like e-mails, phone calls, and the use of community health workers are typically not reimbursed but can help physicians monitor patient compliance and outcomes outside of a traditional office visit.

The current reimbursement system is also procedure-driven; performing more procedures yields more payment. By some estimates, specialists, whose practices are more procedure-driven than primary care, earn more than twice as much as primary care physicians. Annually, primary care physicians earn approximately $173,000, compared to $391,000 by radiologists and $419,000 by

cardiologists.[20] Given that medical school graduates leave school with over $100,000 in debt, financial considerations play an important role in medical students' residency preferences.

Movement toward greater reimbursement parity for primary care services has been initiated on the federal level. Federal health care reform legislation will increase Medicaid reimbursement rates to match Medicare rates for certain primary care services in 2013 and 2014. However, no federal funding was allocated to help states sustain these increases after 2014. Beginning in 2011, the new law also provides a 10 percent reimbursement bonus for 5 years to family doctors, internists, geriatricians, nurse practitioners, and physician assistants who provide qualifying services to Medicare patients.[21]

In response to payment disparities between primary care physicians and specialists, a recent publication in the American Journal of Obstetrics and Gynecology proposed that medical schools cut tuition and fees for medical students and instead collect a fixed percentage of the physician's income for 10 years following the completion of his/her training. The proposal, referred to as the "Strategic Alternative for Funding Education," calls for public medical school graduates to pay 5 percent of their gross income per year and private school graduates to pay 10 percent. Authors of the proposal believe using a fixed percentage could help medical students choose a specialty without worrying about how choosing a lower paying specialty may impact his/her ability to repay student loan debt.[22]

In January 2009, the Josiah Macy Jr. Foundation held a conference at which participants from the various primary care professional groups discussed the future of primary care. Recognizing that the current payment system undervalues primary care, conference participants recommended implementing payment reforms across all health care payers that would more appropriately reimburse for primary care. Specifically, they suggested the use of "global payments," a fixed payment made in advance by a payer to a group of providers or health care system that covers all of the care for a group of patients (e.g., Medicaid beneficiaries). Global payments give primary care providers flexibility to provide services typically not reimbursed under the traditional fee-for-service system such as preventive care, care coordination, chronic disease management, and around-the-clock access.[23] For a more detailed discussion of payment reforms, see Interim Charge 9.

**2. Medicare graduate medical education favors training in hospital settings.** Graduate medical education (GME) is a partnership between medical schools and teaching hospitals to provide supervised, hands-on training of resident physicians. Resident physicians have already completed medical school and use their residency period to gain expertise in a certain field of medicine such as primary care or cardiology. Medical school faculty teaches and supervises the medical residents while teaching hospitals and clinics provide the clinical setting and opportunities to treat patients.[24]

Federal programs that support GME include Medicare, Medicaid, the Department of Defense, and the Department of Veterans Affairs. Of these, Medicare is the largest supporter of GME and compensates hospitals for costs associated with training resident physicians. Costs to hospitals for resident training include stipends for residents, salaries and benefits for supervising faculty, and additional patient care costs.[25]

Because Medicare GME funding flows directly to hospitals, and hospitals are responsible for costs associated with training in non-hospital settings like clinics and physician offices where primary care training would occur, there is a built-in bias toward specialty training in hospital settings.[26] To offset this bias, Texas has focused its GME investments in primary care residency programs. State GME funding began in 1979 and targets primary care physicians who will stay in Texas. However, due to budgetary constraints, funding for these programs has not remained consistent. Table 3 lists the funding history for the various state residency programs.[27]

**Table 3. State-Funded Residency Programs**

| Program | FY 2002-03 | FY 2004-05 | FY 2006-07 | FY 2008-09 | FY 2010-11 |
|---|---|---|---|---|---|
| **Family Practice Residency Program** | $20,599,709 | $18,383,522 | $17,464,310 | $17,464,310 | $21,214,310 |
| **Primary Care Residency Program** | $5,886,460 | $5,253,104 | $4,990,440 | $4,990,440 | $4,990,440 |
| **Graduate Medical Education Program** | $15,200,000 | $3,828,222 | $3,636,804 | $600,000 | $600,000 |
| **Statewide Preceptorship Programs** | $1,941,436 | $997,400 | $904,289 | $904,289 | $904,289 |

Texas also provides Medicaid GME funding to five state-owned teaching hospitals: the University of Texas Medical Branch, University of Texas MD Anderson Cancer Center, University of Texas Tyler, and University of Texas Southwestern's St. Paul and Zale Lipshy hospitals. This program started in fiscal year 2009 and draws down $24.8 million per year in federal funds.[28]

During the recent federal health care reform debate, some groups called for an expansion of Medicare GME slots from 100,000 to 115,000. Rather than expand GME slots, the bill redistributes currently unused GME slots to states with high health care professional shortages and directs that these positions be focused on training primary care physicians and general surgeons.[29] Unfortunately, Texas has received none of the re-distributed slots despite having a significant number of underserved areas.

According to estimates by the Texas Medical Association, Texas had 1,404 medical school graduates in 2010 but only 1,390 first-year residency (GME) slots.[30] This means Texas is losing its investment in medical graduates to other states where residency slots are available, and many of these graduates will not return to practice in Texas. It is important to note that these numbers underestimate the shortage of GME slots because they do not take into account medical school graduates from other states and countries recruited to Texas. In order to address the physician shortage, the state will need to keep its medical school graduates in Texas for residency training and continue to recruit medical graduates from outside of the state; however the shortage of GME slots prevents Texas from doing so.

In light of current budget constraints and the state's primary care shortage, it has been suggested that a portion of the remaining revenue from physician licensure fees be used to add additional GME slots. Some experts estimate that to be sufficient, the number of GME slots needs be 110 percent of the total number of Texas medical school graduates.

**3. No responsibility placed on medical schools.** State funding for medical schools is not linked to a school's ability to provide the state with much needed primary care physicians. Given the state's investment in medical schools, some believe this funding should be combined with specific responsibilities to help meet state needs.

During the 81st legislative session, HB 4471 (Kolkhorst) made changes to the existing Nursing Shortage Reduction Program to link nursing program performance to funding. To encourage nursing programs to produce more nurses, the legislation created a mechanism for the Texas Higher Education Coordinating Board (THECB) to provide up-front funding to nursing programs in exchange for meeting certain graduation rate or enrollment benchmarks. Programs that fail to meet the benchmarks must return unearned funds or have future funds withheld. In light of scarce state resources and an overwhelming shortage of primary care physicians, the state should consider implementing a similar program for medical schools to ensure a return on investment.

Some medical schools are already implementing innovative programs to produce additional primary care physicians. For example, Texas Tech University Health Sciences Center (TTUHSC) recently received approval from the Liaison Committee on Medical Education, the nationally accrediting body for medical education, for a three-year medical school program. The first of its kind in the country, the Family Medicine Accelerated Track (F-MAT) program aims to increase the number of medical students who choose a career in family medicine and prepare these students more efficiently. TTUHSC medical school dean, Dr. Steven Berk, recently stated that the school plans to "hire very enthusiastic family medicine physicians as role models" for the F-MAT program.[31] In light of the state's primary care needs, other medical schools and health professions programs should also consider focusing recruitment on faculty with primary care experience.

As mentioned previously, student loan debt is one of the major factors in medical students choosing higher-paying specialties rather than primary care. Students participating in the F-MAT program will complete medical school training one year earlier and with approximately half of the student loan debt as students in conventional medical school programs.[32] A $1.5 million grant, recently awarded by the U.S. Department of Health and Human Services, will help the F-MAT program provide scholarships, create residency positions, and hire faculty.[33]

Several professional groups have suggested a fast-tracked medical school curriculum for advanced practice registered nurses and physician assistants that takes into account these professionals' previous education, training, and experience. While this concept has gained interest from some of the medical schools, more research is needed on how this curriculum would be designed.

***The Primary Care Team***

Primary care practices typically consist of a team of health professionals who each contribute to a patient's care.

Under current state regulation, physicians may delegate tasks to mid-level practitioners like advanced practice registered nurses (APRNs) and physician assistants (PAs). This delegation allows more patients to be treated and increases access to care. Testimony provided to the Senate Committee on Health and Human Services asserted that current state regulations keep these mid-level practitioners, particularly APRNs, from being utilized to the full extent of their education. Primary care health professionals at a recent conference held by the Josiah Macy Jr. Foundation recommended that, in addition to efforts to increase the *number* of primary care providers, states should work to change *regulatory* and *reimbursement* policies that make it difficult for APRNs (specifically nurse practitioners) and PAs to serve as primary care providers and leaders of primary care delivery models (e.g. medical homes).[34]

Efforts on the federal level are already underway to expand the use of mid-level practitioners. Federal health care reform legislation included several provisions that promote the use of APRNs and PAs in primary care. For a discussion of these provisions and a more detailed overview of the current regulation of APRNs in Texas, see Section III: Advanced Practice Registered Nurses.

***Naturopathic Physicians***

Naturopathic medicine integrates natural and conventional medicine with an emphasis on prevention and treatment of acute and chronic illnesses, maintenance of an individual's optimal health, and promotion of the self-healing process.[35] Naturopathic physicians are licensed as primary care physicians in fifteen states, the District of Columbia, and the U.S. territories of Puerto Rico and U.S. Virgin Islands.[36] In these states and territories, naturopathic physicians are required to attend a four year, graduate-level program at a naturopathic medical college accredited by the Association of Accredited Naturopathic Medical Colleges (AANMC). Naturopathic medical colleges accredited by the AANMC are also recognized by the federal Department of Education.[37]

In practice, licensed naturopathic physicians perform physical examinations, take patient health histories, order lab tests and diagnostic tests, and can prescribe drugs, although the emphasis is on natural medicines and therapies when they can be used safely and effectively. Like conventional primary care physicians, naturopathic physicians work with other practitioners to coordinate patient care and make referrals to specialists or other health care providers when necessary.

In Texas, naturopathic physicians are not licensed or regulated. Without legal recognition as a primary care physician, or even as a medical provider, these individuals practice in Texas as "naturopathic consultants." Naturopathic consultants provide information and suggestions to patients seeking natural forms of treatment.

**Access to Care: A System-Wide Issue**

The previous section focused on access to care issues in primary care; however, shortages exist in nearly every health profession in Texas.

***Nursing***

A 2006 study by the Texas Center for Nursing Workforce Studies projected a shortage of more than 70,000 nurses in Texas by 2020.[38] Like other health professions, the passage of federal health care legislation is likely to increase this figure due to "pent-up" demand for services.

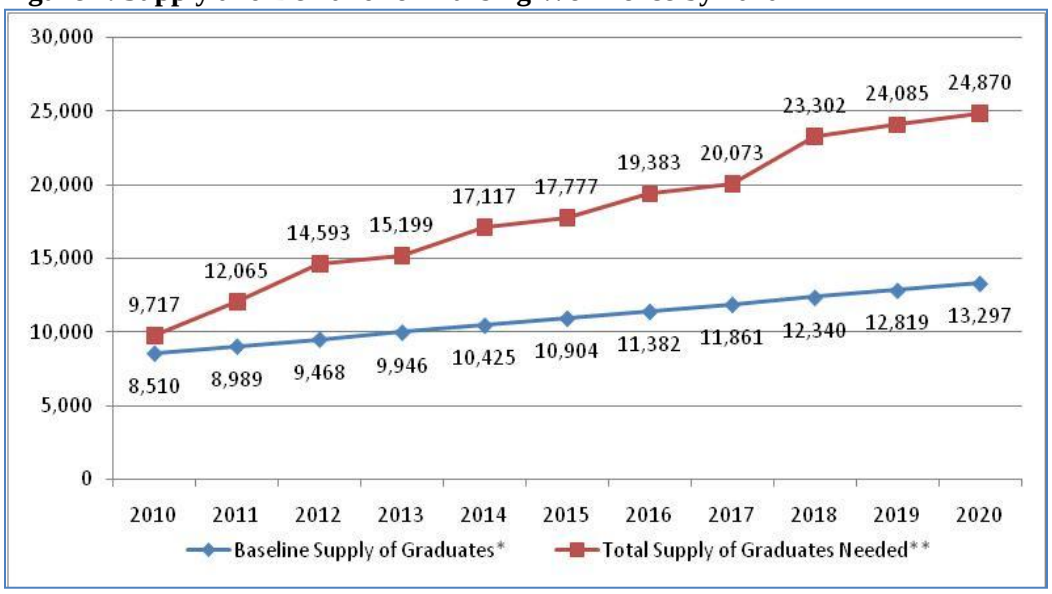
The demographics of the nursing workforce contribute to the state's challenges in meeting the nursing demand. The average age of a nurse in Texas is 46.[39] Within the next 10 years, Texas could lose more than 40 percent of its nursing workforce to retirement.[40]

High turnover rates also contribute to the nursing shortage. According to the 2006 Texas Hospital Nurse Staffing Survey, the turnover rate for registered nurses (RNs) working in hospitals was 18.2 percent.[41] The National Council of State Boards of Nursing (NCSBN) estimates that turnover rates among new nurses are even higher; 35 to 60 percent of nursing graduates leave their position within one year, at a cost to the employer of $46,000 to $64,000 per nurse.[42]

Some attribute the high turnover rate among new nurses to a lack of training and support as they transition from school to practice. To address these high turnover rates, the Texas Board of Nursing (BON) plans to apply for a NCSBN pilot project to test out the NCSBN's "Transition to Practice" model for new nursing graduates. Under this model, new nursing graduates would be paired with a preceptor who works one-on-one with the new nurse for the first six months, with ongoing support for another six months. The model also includes education modules beyond the typical workplace orientation that focus on communication, teamwork, patient-centered care, evidence-based practice, quality improvements, informatics, and clinical reasoning and safety.[43]

In order to meet the demand for nursing and offset the effect of the aging workforce, the state must significantly increase the number of nursing graduates. Figure 4 compares the projected supply of Texas nursing graduates to the projected number of graduates needed.[44] According to these projections, the number of new nursing graduates must increase nearly three-fold in order to meet the demand in 2020.

**Figure 4. Supply and Demand for Nursing Workforce by 2020**



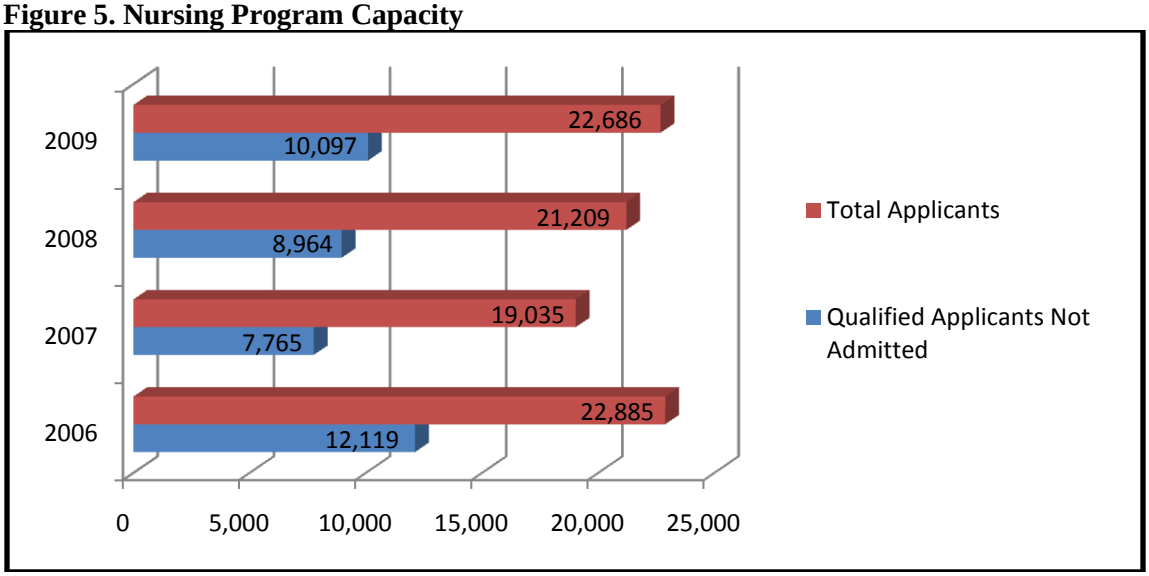

*Based on a simple regression formula of actual graduation data reported from 2002 to 2007. Graduation numbers do not include those from programs that have not yet produced graduates.
**U.S. Health Resources and Services Administration, Supply Model.

The state faces two major obstacles to increasing the number of nursing graduates: program capacity and clinical capacity.

Program Capacity

As Figure 5 indicates, Texas nursing schools turned away over 10,000 qualified applicants in 2009.[45] Higher salaries for nursing faculty in other states and for nurses in clinical practice settings has resulted in a shortage of faculty for Texas nursing programs. Adding to the strain on program capacity, the median age of nurse faculty members is 52, and 65 percent of nurse faculty are age 50 or older.[46] Nursing programs will need to find new faculty to replace existing faculty as they reach retirement age.

**Figure 5. Nursing Program Capacity**



The 81st Legislature made significant investments toward increasing nursing program capacity. Specifically, biennial state funding for the existing Professional Nursing Shortage Reduction Program more than tripled, from $14.7 million to $49.7 million. In addition, House Bill 4471 (81st Legislature, Kolkhorst) made changes to the program to ensure that these state dollars are used effectively.

Table 4 lists other state-funded nursing programs at the Texas Higher Education Coordinating Board (THECB).[47]

**Table 4. State Appropriations for THECB Programs FY 2002-2011**

| Program | FY 2002-03 | FY 2004-05 | FY 2006-07 | FY 2008-09 | FY 2010-11 |
|---|---|---|---|---|---|
| **Professional Nursing Shortage Reduction Program** | 1,447,438 | 4,000,000 | 6,000,000 | 14,700,000 | 49,700,000 |
| **Hospital-Based Nursing Education Program** | N/A | N/A | N/A | N/A | 5,000,000 |
| **Nursing Innovation Grant Program** | 2,400,000 | 4,050,000 | 4,050,000 | 4,050,000 | 4,050,000 |
| **Minority Health Research and Education Program** | N/A | N/A | N/A | N/A | 2,250,000 |

In response to the need for more nurses, Texas nursing programs have coordinated to create a collaboration called the Texas Team. Using a regional approach, the programs are working together to leverage existing resources and federal funding opportunities. Innovative projects include sharing curricula, faculty, best practices, and using a common admissions application. Other health professions programs could use similar collaborative efforts to maximize existing resources. In addition, a number of nursing programs offer accelerated RN programs for college graduates with related undergraduate studies. Innovative efforts like these should be encouraged and supported by policymakers.

Clinical Capacity

As part of the required curriculum, nursing students must complete hours in a clinical practice setting. Increasing nursing program capacity without also increasing opportunities for nursing students to complete the mandatory clinical hours can bottleneck the nursing education pipeline.

In response to the need for innovative solutions to address the clinical capacity issue, nursing programs across the state are using "clinical simulation" to expand clinical capacity. Clinical simulation can include sophisticated mannequins, virtual reality, patient actors ("standardized patients"), and a variety of other technologies that allow students to practice clinical skills and effective communication with no risk to actual patients. Clinical simulation can also expose students to situations not likely to arise during regular clinical rotations, such as disaster scenarios, high-risk patients, and patients presenting with unusual symptoms.[48] A 2008 study supported by the NCSBN compared the performance of nursing students with direct patient experiences only, with simulation experiences only, and with both experiences, and found that

students with a combination of both clinical experiences performed better than students who only received one type of experience.[49]

Recognizing the potential of clinical simulation to help address the nursing shortage, the 81st Legislature appropriated $5 million to the University of Texas at Arlington to establish the Regional Nursing Education Center, which will include a clinical simulation learning facility. Moving forward, clinical simulation will continue to play a critical role in increasing clinical capacity.

Next Steps to Address the Nursing Shortage

As a result of the state's investment in the nursing workforce over the past several legislative sessions, Texas nursing schools experienced an 18.6 percent increase in faculty from the fall of 2007 to the fall of 2009.[50] Texas is currently producing approximately 7,000 new nurses a year, a 55 percent increase over 2001.[51] At the August 4th hearing of the Senate Finance Committee, witnesses credited the Legislature for investing in the nursing workforce, but also emphasized the need for continued support. Due to the recent economic recession, many nurses delayed retirement or worked additional hours. Once the economy stabilizes, many of these nurses will likely retire or return to part-time employment.

***Allied Health***

Allied health includes over 200 distinct disciplines including, but not limited to: clinical laboratory scientists (medical technologist), physical therapists, respiratory therapists, emergency medical technicians and paramedics, occupational therapists, speech-language pathologists, and physician assistants. These professionals comprise approximately 60 to 65 percent of the health care workforce and provide essential services to patients and other health care providers. It is estimated that for every physician, 8 to 10 allied health professionals are required. The U.S. Department of Labor predicts a shortage of 1.6 to 2.5 million allied health workers in the U.S. by 2020.[52]

Like nursing, allied health programs are turning away qualified applicants due to a lack of program capacity. Recommendations presented to the Senate Committee on Health and Human Services for addressing the allied health care workforce shortage included increasing the capacity of current allied health programs, providing financial incentives for students similar to current programs for nurses and physicians, and increasing public awareness of the allied health professions. Partnerships between high schools, community colleges, universities, and health-related institutions of higher education to provide dual credit courses and pre-professional training can also increase the capacity of the allied health educational pipeline.[53]

***Dental Health***

Unlike other health professions, the number of dentists graduating from Texas dental schools in combination with the number of dentists coming to Texas from other states is thought to be sufficient to meet the demand for dental services. However, there is an undersupply of dentists in border and rural areas of the state that stems from a mal-distribution of dentists, rather than a statewide undersupply. It is estimated that dentists must have a patient base of 30,000 in order to have a viable dental practice. Securing an adequate patient base can be challenging in rural areas

of the state.[54] For a more detailed discussion about the mal-distribution of health professionals in Texas, see Challenge 2: Mal-distribution of Health Care Professionals.

To increase access to dental care for Texas children, the Texas Dental Association, American Academy of Pediatric Dentistry, Texas Academy of Pediatric Dentistry, Texas Academy of General Dentistry, Texas Dental Hygienists' Association, and Department of State Health Services (DSHS) have partnered together to match all Texas children enrolled in Head Start with a dental home by 2011. When possible, DSHS also partners with charitable dental organizations to provide dental care at community health centers to individuals who otherwise would not be able to obtain it.[55]

Some individuals testifying at the February 23rd hearing of the Senate Committee on Health and Human Services recommended rebuilding the state's Oral Health Program at DSHS to include the dental fee-for-service voucher program which existed prior to state budget cuts in 2003. They also recommended increasing the number of dentist and dental hygienist positions in each of the state's health service regions to increase the number of children served by the Oral Health Program.[56] In making any additional investment in the Oral Health Program, the Legislature may want to consider that one dentist can supervise multiple dental hygienists.

***Mental Health***

Mental health professionals include psychiatrists, psychologists, social workers, licensed professional counselors, licensed chemical dependency counselors, marriage and family therapists, psychoanalysts, psychiatric nurses, and advanced practice nurses who are recognized in Psychiatric/Mental Health/Substance Abuse (P/MH/SA). As of October 2009, Texas had 173 counties designated as whole county mental health HPSAs.[57] Like other health professions, the supply of mental health professionals in Texas is higher in metropolitan areas than in non-metropolitan areas.

Child and Adolescent Psychiatrists

Like the rest of the country, Texas suffers from a shortage of Child and Adolescent Psychiatrists (CAPs), who specialize in the evaluation, diagnosis, and treatment of mental health disorders in children and adolescents. Eighty percent of Texas counties, predominately rural, do not have a CAP. DSHS recently conducted a study to determine the impact of this shortage on the delivery of mental health service to indigent Texas youth. The agency found that 66 percent of psychotropic medication prescriptions written for children in Medicaid were written by non-CAPs. Using encounter data from Local Mental Health Authorities (LMHAs), DSHS also found that children seen at a LMHA in a rural county were less likely to see a CAP than children seen at a LMHA in a metropolitan county. Telemedicine services will be critical to allow CAPs in urban areas to provide psychiatric services to youth in rural areas.[58]

State Mental Health Hospitals

Another issue plaguing the state's mental health system is low wages in state mental health hospitals. As of April 2010, the psychiatrist vacancy rate across all DSHS state hospitals was approximately 13 percent (a vacancy rate over 10 percent is considered critical). Several of the state mental health facilities have at least a quarter of psychiatrist positions unfilled. The Rio Grande State Center has an alarming vacancy rate of 48 percent. These shortages can be

attributed in part to the state's inability to compete with psychiatrist salaries in the private sector. Starting salaries among psychiatrists at the state mental health hospitals are even lower than starting salaries in other public facilities, such as state-supported living centers. The shortage of psychiatrists in the state's mental health hospitals adversely impacts patient care, including reducing hospital capacity, increasing the potential for injuries and adverse events, and reducing the amount of individual care that each patient receives. It can also cause a state hospital to lose its accreditation status, and consequently its Medicare certification and payment from federal (Medicare/Medicaid) and private payers.[59]

Social Workers

Social workers are the largest group of licensed mental health providers in the state and provide or administer 60 percent of mental health services in Texas. Over the next decade, there will be an 18 to 24 percent rise in the need for social workers. However, the supply ratio of social workers in Texas has declined over the last decade from 74 to 68 per 100,000 people from 1999 to 2008. Like other health professions, the supply ratios in rural and border areas are lower than urban, non-border areas.[60] Social workers play a critical role in the health care delivery system, helping patients manage chronic diseases through education, treatment plan and medication adherence, monitoring of outcomes, and counseling. Successful management of chronic diseases in the community can help lower health care costs by preventing more serious conditions and costly emergency room visits.

**Access to Care within Medicaid**

There are currently not enough physicians in Texas willing to treat Medicaid patients and the problem will only worsen under federal health care reform which is expected to increase Medicaid enrollment to 6.2 million. Approximately 47,000 physicians in Texas are currently enrolled in Medicaid to serve the program's 3.1 million enrollees. Using these figures, the state has 65 Medicaid enrollees to every Medicaid physician. However, the number of physicians *actively* serving Medicaid clients is only 14,500.[61] Using this figure, there are actually 214 Medicaid enrollees per physician.[62] Assuming that the number of physicians in Texas does not significantly increase, the ratio under federal health care reform will be approximately 132 enrollees to every physician enrolled as a Medicaid provider, and 428 enrollees to every *active* physician.[63] It is important to note that even the physicians actively serving Medicaid enrollees typically have a mix of privately insured and Medicaid patients.

***Transition Medicine***

Individuals with disabilities are one of the primary groups served by the Medicaid program. While advancements in medicine have allowed individuals with disabilities and serious illnesses to live longer, the availability of health care providers to serve this population has not kept up. As children with serious illnesses or disabilities reach adulthood, they are finding that their pediatric specialist will no longer see them and adult specialists are unfamiliar with their conditions, many of which were once thought to be confined to childhood (congenital heart disease, cystic fibrosis, spinal bifida, down syndrome, sickle cell disease). Transition medicine ("Meds-Peds") physicians are doctors trained in pediatrics and internal medicine. These physicians are trained to understand the implications of childhood illnesses and can treat patients throughout their life. Two medical schools in Texas, Baylor College of Medicine and the University of Texas at Houston, offer Meds-Peds training programs. Baylor College of

Medicine houses one of only seven transition medicine clinics in the country where health care providers can be trained to provide care to adolescents and adults with serious chronic illnesses or disabilities.

***Community-Based Services and Supports***

In addition to living longer, individuals with disabilities are living more independently. Direct support workers such as home health aides, nursing aides, orderlies, attendants, and personal and home care aides provide support to the elderly and individuals with disabilities so that they may live independently in the community. One of the fastest growing occupations in the country, direct support workers, is projected to be the second largest occupational group by 2018. In Texas, the demand for new direct support workers is expected to increase by 45 percent between 2006 and 2016.[64] Low wages, high turnover rates, and significant recruitment costs for providers continue to plague this profession and hinder its ability to keep up with demand. In 2009, Executive Commissioner Thomas Suehs of the Health and Human Services Commission (HHSC) directed HHSC and the Department of Aging and Disability Services (DADS) to establish an advisory council to study and make recommendations on direct support workforce issues.[65]

***Budget Considerations***

In light of the anticipated state budget shortfall, state leadership asked agencies to identify options to reduce their budgets for the current biennium by 5 percent. Included in the approved reductions for the Health and Human Services enterprise was a 1-percent Medicaid provider reimbursement rate decrease beginning September 1, 2010. In March, the Texas Medical Association (TMA), which represents 43,000 physicians and medical students, surveyed its members about possible Medicaid reimbursement cuts and obtained alarming responses. Asked how they would respond to a 1 or 2 percent Medicaid reimbursement cut, 45 percent of respondents said they would limit their number of Medicaid patients, 38 percent would no longer accept new Medicaid patients, and 24 percent would terminate relationships with all Medicaid patients.[66] For the 2012-2013 biennium, state agencies have been asked to identify an additional 10 percent in budget reductions.

TMA estimates that the state invests more than $200,000 per Texas medical student.[67] In light of the shortage of physicians willing to serve Medicaid patients, some have suggested requiring physicians who receive state-supported medical education or training to treat a certain percentage of Medicaid patients.

The current shortage of providers serving the Medicaid population raises the possibility of additional legal action against the state. In 2007, Texas settled the *Frew vs. Suehs* class action lawsuit, which alleged that the state failed to ensure that all children enrolled in Medicaid received preventive care guaranteed under the federal Early Periodic Screening Diagnosis and Treatment Act. As part of the $1.8 billion settlement, Texas agreed to increase physician and dental reimbursement rates, improve outreach and education to Medicaid recipients, and improve access to medical and dental services in rural and border areas of the state.[68] HHSC has implemented a number of strategic initiatives to improve access to care for Medicaid children including the First Dental Home project, Mobile Dental Unit in the Valley, and the Children's

Medicaid Loan Repayment Program. In its 2012-2013 legislative appropriations request, HHSC included an exceptional item request to maintain funding for *Frew* initiatives at a biennial cost of $91 million in General Revenue. This funding is necessary to continue compliance with the *Frew* settlement, and failure to comply could result in additional court action against the state.[69]

**Increasing Access to Care Through Workforce Study and Planning**

Over the years, the state has established a number of resources to study health care workforce issues including access to care. Some of these resources include the Statewide Health Coordinating Council (SHCC), the Texas Center for Nursing Workforce Studies (TCNWS), and the Health Professions Resource Center (HPRC).

The broad purpose of the SHCC is to provide guidance to the state in its efforts to ensure that all Texans have access to health care. Specifically, the SHCC makes recommendations to the Governor and Legislature through its Texas State Health Plan. It also has statutory oversight of the TCNWS and the HPRC.

In response to the state's nursing workforce shortage, the 78th Legislature created the TCNWS to serve as a resource for nursing data and workforce research. Its advisory committee develops priorities and operations plans for the TCNWS, provided policy recommendations, identifies issues that need additional study, and reviews TCNWS reports and information prior to publication.[70]

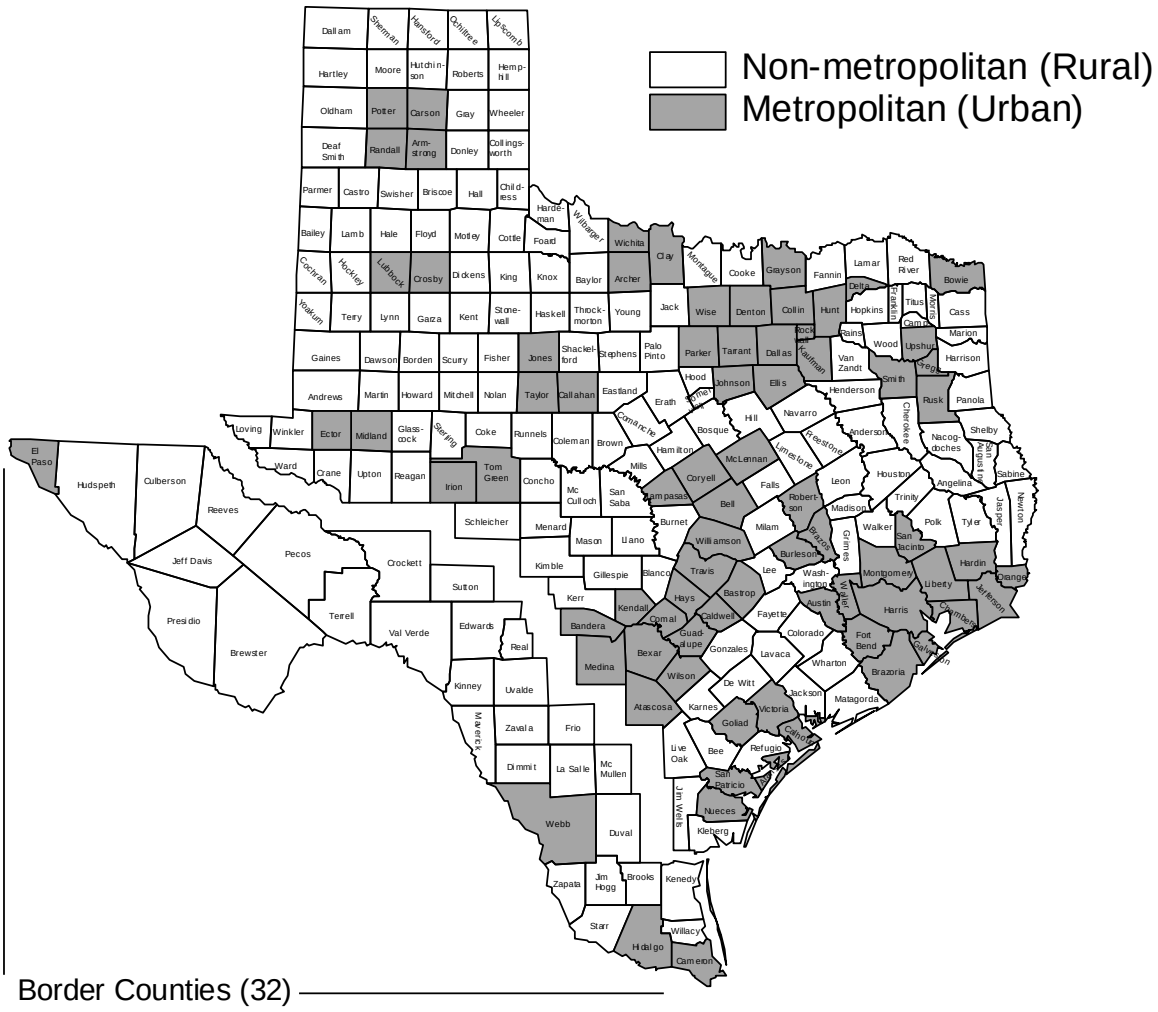
Created in 1989, the HPRC serves as the primary source of health professions workforce data in Texas. It collects, analyzes, and disseminates data related to the supply, distribution, and demographics of the health care workforce. This data is used by the SHCC for inclusion in the State Health Plan. The HPRC also studies and prepares reports on specific health care workforce issues. Unlike the TCNWS, the HPRC does not currently have an advisory committee to provide expertise and help prioritize its work.

At its February 23rd hearing, the Senate Committee on Health and Human Services received numerous recommendations to require specific health workforce studies. Rather than statutorily require all of these studies, a process to coordinate and prioritize health professions workforce studies should be developed. One way to achieve this would be for the SHCC to form an ad hoc advisory committee to the HPRC to address specific workforce issues facing the state such as access to health care, scope of practice, effects of federal health care reform, etc.

## Challenge 2: Mal-distribution of Health Care Professionals

Although the entire state suffers from health care workforce shortages, they are more pronounced in the rural and border counties. Figure 6 distinguishes between non-metropolitan (rural), metropolitan (urban), and border counties in Texas.[71] As the map indicates, a vast majority of border counties are also classified as rural.

**Figure 6. Texas Border and Metropolitan Counties, 2009**




State health professions licensure data supports the observation that the health care workforce is not distributed across the state in proportion to the general population. For example, Figure 7 compares the ratio of physicians to population in metropolitan (urban) areas of the state to non-metropolitan (rural) areas.[72] The physician supply, in relation to population, is nearly twice as high in urban areas of the state compared to rural areas. This trend is common among the other health professions as well.

**Figure 7. Direct Care Physicians per 100,000 Population (Urban versus Rural)**

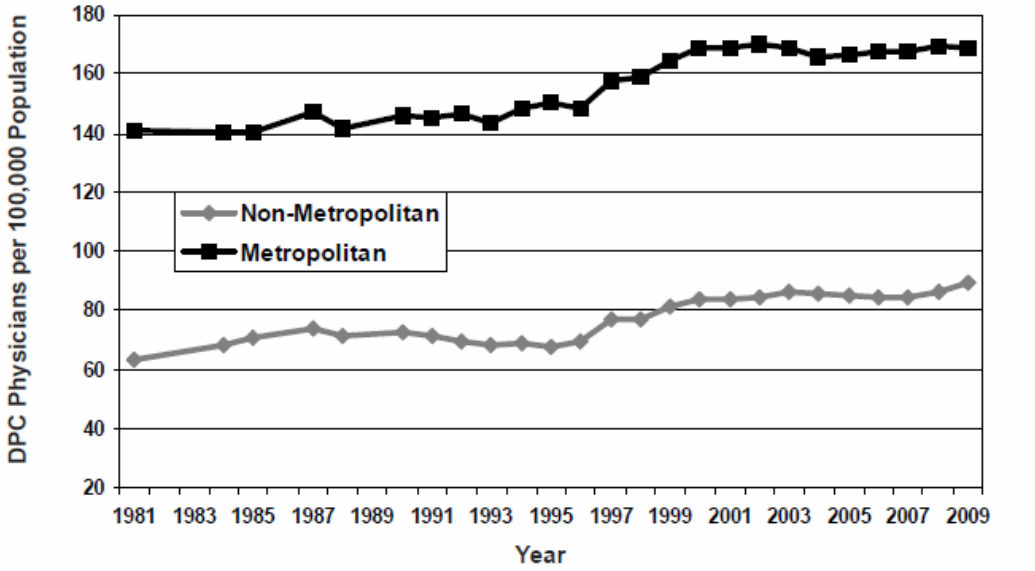



Table 5 highlights the discrepancy in the ratios of selected health care professionals to population between not only urban and rural areas, but also border and non-border areas.[73] In each case, rural and border areas of the state fare worse than the state average, while metropolitan, non-border areas fare better.

**Table 5. Health Care Professionals per 100,000 Population by Metro and Border Area**

| | Physicians (All) | Primary Care Physicians | Nurse Practitioners | Registered Nurses | Physician Assistants | Dentists |
|---|---|---|---|---|---|---|
| **Rural, Non-border** | 95 | 57 | 16 | 499 | 14 | 27 |
| **Rural, Border** | 53 | 37 | 9 | 252 | 17 | 13 |
| **Metro (Urban), Non-border** | 175 | 72 | 25 | 735 | 19 | 42 |
| **Metro (Urban), Border** | 110 | 53 | 17 | 519 | 16 | 19 |
| **Statewide** | 159 | 68 | 23 | 684 | 18 | 38 |

The mal-distribution of health professionals in Texas can be attributed to a number of factors:

**1. Unfavorable payer mix**: Rural and border residents tend to be disproportionately uninsured or insured through Medicaid or Medicare compared to urban areas of the state. Medicaid pays health care providers about 73 percent of what Medicare pays, and only about 50 percent of private health insurers.[74] Without a large base of privately insured patients to offset lower paying public insurance programs, rural and border health care providers struggle to create a financially sustainable business model.

**2. Economies of scale**: The challenges physicians face in establishing a new medical practice are the same as those to starting any small business. Low patient volume keeps rural health care providers from achieving the same economies of scale as providers in more populated

metropolitan areas. Fluctuations in patient utilization of services make practices in these areas less predictable and less attractive to providers looking for a place to establish a practice.

Rural advocates argue that a current state law intended to prevent hospital administrators from having an improper influence over treatment decisions by physicians exacerbates physician shortages in rural areas of the state.[75] The Texas Organization of Rural and Community Hospitals (TORCH) has testified numerous times before the Legislature that this law has created an obstacle for physicians who are interested in practicing in rural communities but cannot afford the overhead costs (or the financial risk) of starting their own practice. Exemptions to the prohibition include medical schools, federal health clinics, and non-profit health care corporations. The 81st Legislature passed HB 3485 (Coleman), which included an amendment allowing exemptions for the Dallas County Hospital District and government-run rural hospitals in counties with less than 50,000 residents. However, the bill was vetoed due to concerns about another amendment.[76]

**3. Inadequate health care infrastructure:** Many of the state's level I and II trauma centers are concentrated in Central and North Texas. Texans in 85 percent of the state are more than the "golden hour" away from a level I trauma center. Smaller rural and community hospitals help fill these gaps, providing essential triage and stabilization until patients can be transferred to a larger trauma facility. However, since 1980, almost 100 Texas rural hospitals have closed.[77] According to Don McBeath, director of advocacy for the Texas Organization of Rural and Community Hospitals, the best thing lawmakers can do to improve rural trauma care in Texas is support these small local hospitals.[78]

Local emergency medical services (EMS) systems, which provide pre-hospital care and transportation, also play an integral part in the state's health care system and face unique infrastructure challenges in rural areas when compared to their urban counterparts. Vast distances between communities and from urban areas where Level I and II trauma facilities are located result in longer transport times for patients and higher travel costs for EMS providers. Rural areas also have low call volumes and high overhead costs, making them unappealing to private EMS providers. As a result, these areas tend to rely on volunteer personnel. Although funding issues plague both rural and urban EMS systems, rural systems particularly struggle to replace aging equipment and keep up with advancements in medical technology.[79]

Each year, the U.S. Department of Housing and Urban Development provides community development block grants directly to states to be distributed to small, rural cities with populations less than 50,000 and to counties that have a non-metropolitan population under 200,000. The Texas Department of Rural Affairs administers this program on the state level and ensures that city/county projects meet the federal requirements. In light of current economic conditions and the importance of supporting the rural health care system, communities should be encouraged to focus these federal grants on projects related to health care infrastructure if feasible.

**4. Location of health professions schools:** Health professions programs are typically located in metropolitan areas. From a resource perspective, this makes sense given that these areas have a number of clinical opportunities to offer students. However, the lack of programs in

rural areas exacerbates the mal-distribution because health professionals tend to practice near where they received their education and training.

Distance learning education allows individuals who live in rural communities without a nearby university to access health professional education otherwise unavailable to them. SB 290 (81R, Nelson) would have created a grant program through the Texas Higher Education Coordinating Board to encourage health professional education programs to offer new or expand existing distance learning or community-based education.

To increase the number of students from rural areas who pursue a career in health care, health professions schools should be encouraged to devote faculty time to coordinate rural health curriculum and community-based clinical rotations, offer rural health courses, reserve admissions slots for rural candidates, provide rural tracks for professional and graduate students, and provide rural community-based clinical experiences for academic credit.

**5. Lifestyle:** In some areas of the state, a health care professional may be the only provider in the entire county. In these communities, residents may know where the provider lives and stop by after hours or in case of an emergency. These providers are essentially on-call 24 hours a day, 7 days a week, which may not be an appealing lifestyle for many health care providers. Families of these health professionals may also have difficulty finding employment in more remote rural areas.

Rural health care providers may also find the isolation from other health professionals to be challenging. To help alleviate this professional isolation, some health care providers have forged innovative partnerships with academic health science centers for mentoring, consults, and continuing medical education.

**State Actions to Correct the Mal-distribution of Health Care Professionals**

The vast size and geography of Texas create unique challenges for rural and border areas not faced by urban areas of the state. The state has implemented several programs to address these challenges and cultivate a stronger health care workforce to serve Texans in these areas.

***Loan Repayment Programs***

Texas' efforts to correct the mal-distribution of health care professionals have focused primarily on loan repayment programs, the largest of which is the Physician Education Loan Repayment Program (PELRP). Initiated in the late 1980s, the PELRP is the oldest of the state loan repayment programs and provides loan forgiveness for physicians who serve in health professional shortage areas. The 81st Legislature strengthened the PELRP by increasing funding through a restructure of the state tobacco tax. The PELRP now provides loan repayment of up to $180,000 over four years to physicians who practice in a designated HPSA. Similarly, the Dental Education Loan Repayment Program (DELRP) provides loan repayment up to $10,000 a year, until loans are paid off, to dentists who work in a dental HPSA. Finally, HHSC created the Children's Medicaid Loan Repayment Program (CMLRP) as part of the *Frew* settlement. The CMLRP provides loan repayment of up to $140,000 over four years for physicians and dentists who see Medicaid children.

The Texas Primary Care Office (TPCO) at DSHS provides administrative support to the Texas Higher Education Coordinating Board and HHSC for the state's loan repayment programs by promoting the programs (particularly to physicians still in training), processing applications, and scoring and selecting participants. Detailed requirements for each of the state's loan repayment programs can be found on the TPCO website at: www.dshs.state.tx.us/chpr/TPCO_INFO.shtm.

Public input at the February 23rd hearing of the Senate Committee on Health and Human Services suggested implementing state loan repayment programs, similar to those for physicians and dentists, for nurses, physician assistants, social workers, emergency medical services professionals, and other allied health professionals. While no state loan repayment programs currently exist for these professionals, the National Health Service Corps (NHSC) provides loan repayment to physicians, nurse practitioners, physician assistants, dentists, dental hygienists, and behavioral health clinical specialists who agree to work a minimum of two years in a HPSA. The NHSC also provides scholarships to health professions students who agree to serve one year in a HPSA for each year they receive the scholarship. Federal health care reform legislation included $1.5 billion in additional funding for the NHSC. In light of current budget constraints, it will be critical to find revenue sources for any new state-supported loan repayment programs.

***Visa Programs***

Graduates from foreign medical schools provide an important supply of physicians to the state. Two types of visas, J-1 and H-1B, allow these physicians to practice in Texas.

J-1 Visa

Currently, physicians who enter the U.S. for training may enter on a J-1 visa. After completing training, the J-1 visa requires that these physicians return to their home country for two years prior to returning to practice in the U.S. However, the Conrad 30 federal program allows each state to recommend up to 30 waivers for J-1 visas, which waive the "return home requirement" as long as a physician works in an underserved area. Texas has had no problem finding physicians to participate in this waiver program and regularly receives more than 30 applications for these slots.

H-1B Visa

Physicians may also enter the U.S. on an H-1B visa, which does not have the same return home requirement or service obligation as the J-1 visa. Senate Bill 86 (81st Legislature, Nelson) would have added a service obligation for these individuals, increasing access to health care in underserved and shortage areas. Specifically, S.B. 86 would have required individuals applying for a Texas medical license who are not U.S. citizens or permanent residents to practice medicine in a medically underserved area (MUA), health professional shortage area (HPSA), or at a graduate medical training program for at least three years.

***Area Health Education Centers***

The East, West, and South Texas Area Health Education Centers (AHECs) are part of a national network of AHEC programs based in academic health science centers that carry out a broad program plan through regional community-based centers. AHEC initiatives are designed to address health workforce distribution, quality, efficiency and effectiveness; community health literacy; and local health system issues. The AHECs play a critical role in recruiting health

professionals to underserved communities through their community-based educational placements, K-12 programs, continuing education program, and the Texas Health Match website, which links health professionals looking for jobs with communities looking for providers. In light of the severe workforce shortages in the state, careful consideration should be given to maintaining state resources for these programs next session.

***Federally Qualified Health Center Incubator Program***

Federally Qualified Health Centers (FQHCs) provide comprehensive health care services to indigent, uninsured, and underserved Texans. There are a number of federal benefits linked to the FQHC designation: federal grant funds to support operation and services, enhanced Medicaid and Medicare reimbursement, federal tort claim coverage, and eligibility as a practice site under the National Health Service Corps. Realizing the numerous benefits of FQHCs, the Legislature passed SB 610 (78th Legislature, Nelson) in 2003, creating the Texas FQHC Incubator Program, and SB 526 (81st Legislature, Nelson), reauthorizing the program in 2009. Under the FQHC Incubator Program, DSHS provides grants and technical assistance to help facilities qualify for the FQHC designation. Of the 64 FQHCs currently operating in Texas, 24 became an FQHC through the Texas FQHC Incubator Program.[80]

***Telemedicine***

Telemedicine is a method of health care service delivery that can connect patients in remote areas of the state to health care providers hundreds of miles away using advanced telecommunications technology. Its use in the Texas Medicaid program began in 1998 to increase access to care in rural and underserved areas of the state. Legislation each session from 2001 to 2009 has expanded on and improved the provision of telemedicine services in the Texas Medicaid program. As a result, the use of telemedicine within Medicaid has grown rapidly. In fact, HHSC found that from fiscal years 2007 to 2009, the total number of telemedicine providers increased by 84 percent, while the number of Medicaid clients receiving telemedicine services increased by 233 percent over the same time period. [81]

Realizing the benefits of telemedicine, HHSC has used funding under the *Frew* settlement to contract with the University of Texas Medical Branch (UTMB) at Galveston and the Texas Tech University Health Science Center (TTUHSC) to increase access to care for Medicaid children and decrease travel time and time away from school. UTMB has used the funding to establish the UTMB/HHSC TeleHealth Network for Children to provide pediatric psychiatry services. The project began in August 2009 and will operate 18 patient sites. TTUHSC has used the funding to roll out Project CHART (Children's Healthcare Access for Rural Texas) to increase access to pediatric subspecialists. Project CHART began in August 2009 and will operate 25 patient sites. Both projects are intended to be financially sustainable after the two-year grant period ends in July 2011.[82]

## Challenge 3: Implementing Health Information Technology

Health information technology (HIT) has the potential to increase the quality, efficiency, and safety of the health care delivery system. Through the American Recovery and Reinvestment Act of 2009, the federal administration is investing billions of dollars into HIT. Specifically, the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program will provide incentive payments to qualified health care providers for implementing EHR technology. As

health care providers and hospitals make the transition from paper-based to electronic health records, the demand for HIT professionals will grow rapidly.[83]

By some estimates, the country needs at least 50,000 additional qualified HIT professionals to help health care providers move towards adoption and meaningful use of EHR technology. According to the David Blumenthal, the National Coordinator for Health Information Technology, "modernizing our health care system requires the mobilization of an educated and talented workforce. By supporting such training we will accelerate the meaningful use of health IT and create tens of thousands of secure jobs when and where they are desperately needed." These professionals will need to not only understand HIT, but also how implementing it in a clinical setting impacts patient care and workflow.[84]

In response to this growing workforce need, Texas State University and the University of Texas at Austin partnered earlier this year to take advantage of federal funding available for university-based HIT education. The Texas consortium received a total of $5.4 million, of which $2.7 million went to UT Austin to help fund its new HIT program. This funding allowed the university to implement an intensive nine-week Summer HIT Certificate program, the first of four programs it will offer. This summer, the program graduated its first class of 54 students who each earned certification as a *Health Information Manager and Exchange Specialist*. Fifty-two percent of eligible graduates from this summer program have already been hired. The Summer HIT Certificate program will be repeated in 2011, 2012, and 2013. The university is also developing three additional certificate programs that will be offered in the next three years.[85] Continued investment in these and similar education programs will be critical to meeting the state's growing HIT workforce needs.

## Section III. Advanced Practice Registered Nurses

As mentioned previously, one type of mid-level practitioner is the advanced practice registered nurse (APRN). As the title suggests, an APRN is a registered nurse (RN) with advanced education. An RN with a bachelor's degree in nursing science must complete an additional two to three years of graduate level education and 500 to 1700 clinical hours to become an APRN. This advanced education includes courses on medical diagnosis and prescribing. In addition, APRNs in Texas must be nationally certified and receive APRN licensure through the Texas Board of Nursing (BON).[86]

There are four types of APRNs, each with a specific scope of practice based on their education and training. An overwhelming majority (70-80 percent) of APRNs work in a primary care setting.[87] Table 6 outlines the four types of APRNs and their roles.[88]

**Table 6. Types of Advanced Practice Registered Nurses**

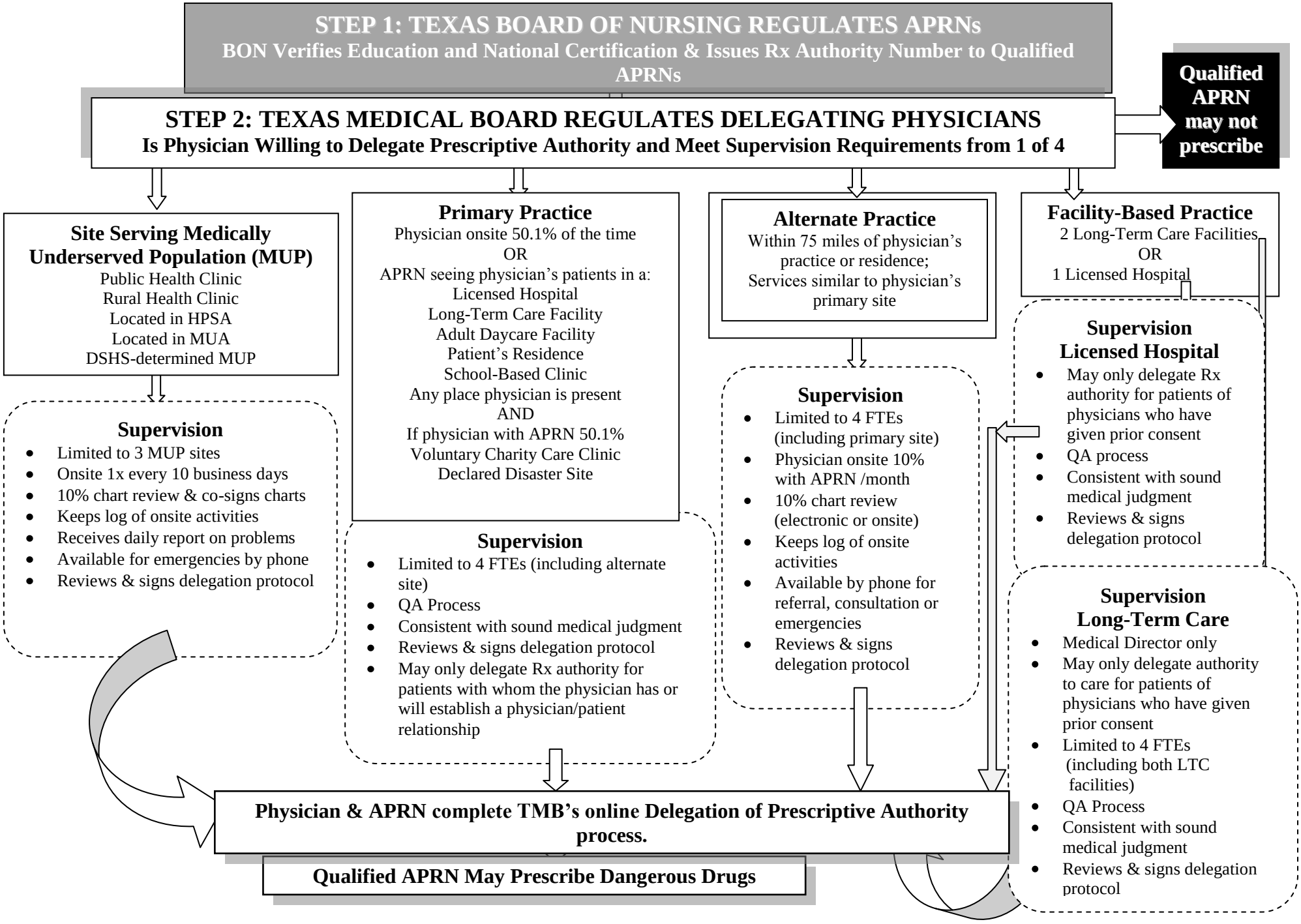
| Type of Advanced Practice Registered Nurse | Description |
|---|---|
| Certified Registered Nurse Anesthetist (CRNA) | • Provide anesthesia services for all ages (including surgical, obstetric, trauma stabilization, and pain management).<br>• Determine type of anesthesia, select and administer drugs. |
| Certified Nurse-Midwife (CNW) | • Provide prenatal/postpartum care, delivery, neonatal care, and women's health over the lifespan.<br>• Only practitioner with specific education on delivery in low resource situations. |
| Clinical Nurse Specialist (CNS) | • Improve quality of care through research, education, and practice.<br>• Primarily work in specialty clinics, hospitals, or as nurse educators and focus on patients with complex health needs. |
| Nurse Practitioner (NP) | • Treat a specific population such as children or adults.<br>• Provide preventive care and treat common illnesses.<br>• Primarily work in clinics and private practices. |

***Regulation of APRNs in Texas***

APRNs practice under the authority of their license from the BON and can provide a number of services independently. This includes patient assessments (history, physical exam, ordering and interpreting diagnostic tests), recommending over-the-counter medications, referrals, consults, coordination of care, and patient education.[89] In order to establish a medical diagnosis, prescribe drugs, or order drugs and medical devices, an APRN must have a delegating physician and practice in a qualifying site.[90] There are four types of sites at which a physician may delegate authority to an APRN and supervisory requirements for delegating physicians vary depending on the practice site. [91]

The following flow chart summarizes this physician-delegated, site-based prescriptive authority model in more detail.[92] Under this regulatory system, an APRN's practice depends on finding a physician willing to fulfill the corresponding site-based supervisory requirements.

# Diagram of Delegated-Site-Based Prescriptive (Rx) Authority for APRNs in Texas



***The Future of APRN Regulation in Texas***

While there is consensus that APRNs play an integral role on the health care team, there is disagreement on what that role should be.

Last session, the Legislature passed SB 532 (81st Legislature, Patrick) which made changes to the requirements for APRNs who practice in alternate practice sites, mainly increasing the number of APRNs a physician may delegate to and increasing the distance a physician's alternative site may be from the physician's primary practice site.

Despite these changes, some believe that the current site-based supervision system creates an administrative burden on both APRNs and physicians and limits patient access to care. Rather than continue amending the current regulations, which they argue only add to the complexity, these stakeholders recommend allowing APRNs to practice independently within the scope of practice already granted to them by their APRN license. Several bills during the last legislative session would have removed some or all of the physician delegation and practice site requirements, but did not pass.

The Coalition for Nurses in Advanced Practice (CNAP), which represents APRNs in Texas, believes that, given the ability to practice independently, APRNs could fill in gaps where physicians currently do not practice, increasing access to care. To ensure that this happens, lawmakers could restrict independent prescriptive authority to APRNs serving medically underserved populations. If lawmakers choose not to allow APRNs to practice independently, CNAP strongly recommends simplifying the regulatory structure by eliminating the site-based restrictions. Under this regulatory model, APRNs would still be required to have prescriptive authority delegated to them by a physician, but the APRN and physician would determine the supervision arrangement.

However, some believe the current physician-delegated, site-based model creates a careful balance between practice and supervision. According to the Texas Medical Association, changing the current model, either to independent prescriptive authority for APRNs or a prescriptive agreement with no site based requirements, could jeopardize patient safety. According to TMA, physician delegated authority allows APRNs to safely provide services permitted by their education, training, and skills. This system allows physicians to retain authority, and ultimate responsibility, for their patients.[93]

# Section IV. Conclusion

Texas faces unprecedented population growth, continued aging of the population and health care workforce, and implementation of federal legislation that will add millions of individuals to the health care delivery system. State budget constraints will require that health care providers, educators, advocates, patients, and state agencies come to the table with creative solutions to address the state's health care workforce needs.

## Section V. Recommendations

**Primary Care**

1. **The Legislature should place responsibility on medical schools and residency programs to produce more primary care physicians, especially those that will practice in rural areas.**

2. **Medical schools should consider "fast-track to physician" programs for physician assistants and advanced practice registered nurses with an abbreviated medical school curriculum based on prior education, training, and skills.**

3. **Health professions schools should be encouraged to hire faculty with primary care experience.**

4. **Encourage nurse-midwifery education programs in areas where none exist.**

5. **Advanced practice registered nurses and physicians should partner to find a policy solution to address the state's primary care shortage.**

**Medicaid**

6. **The Legislature should ensure that funding for Frew initiatives is maintained.**

**Rural and Border Areas**

7. **Texas should require individuals using a H-1B visa to practice in Texas to fulfill a service requirement in underserved areas of the state.**

8. **The Statewide Health Coordinating Council should consider appointing an ad hoc advisory committee under its current statutory authority that will act as a steering committee for the Health Professions Resource Center.**

9. **Health professions schools should be encouraged to devote faculty time to coordinate rural health curriculum and community-based rotations, provide rural health courses, reserve admissions slots for rural candidates, provide rural tracks for professional and graduate students, and provide rural community-based clinical experiences for academic credit.**

[1] Dr. Karl Eschbach, *Testimony before the Senate Committee on Health and Human Services,* p4, (Austin, TX, February 23, 2010).
[2] *Id.* at p9.
[3] Medicare is a federal health insurance program that primarily serves adults over the age 65.
[4] Medicare Payment Advisory Committee, *Report to Congress: Promoting Greater Efficiency in Medicare*, June 2007, p7.
[5] Dr. Karl Eschbach, *Testimony before the Senate Committee on Health and Human Services,* (Austin, TX, February 23, 2010).
[6] Health and Human Services Commission, *Testimony before the House Select Committee on Federal Legislation,* p6 and 21-22, (Austin, TX, April 22, 2010).
[7] Dr. Karl Eschbach, *supra* note 1 at p19.
[8] Dr. Susan Sportsman, Texas Nurses Association, *Testimony before the Senate Committee on Health and Human Services,* p6 (Austin, TX, February 23, 2010).
[9] Health Professions Resource Center, *Supply Trends Among Licensed Health Professions Texas, 1980-2009,* p. *xi* (Executive Summary), Available: http://www.dshs.state.tx.us/CHS/HPRC/09trends.pdf, Accessed: October 21, 2010.
[10] *Id.* at p9.
[11] Dr. Ben Raimer, *Testimony before the Senate Committee on Health and Human Services (Panel 1),* p5, (Austin, TX, February 23, 2010).
[12] Health Professions Resource Center, *supra* note 9 at p9.
[13] *Id.* at p16,40.
[14] *Id.* at p22-71.
[15] *Id.* at p18.
[16] Starfield, Barbara. *Primary Care: Balancing Health Needs, Services, and Technology*. New York: Oxford University Press, 1998.
[17] Health Professions Resource Center, *supra* note 9 at p18.
[18] *Id.* at p19.
[19] Dr. Karl Eschbach, *supra* note 1 at p17.
[20] The Henry J. Kaiser Family Foundation, *Primary Care Shortage: Background Brief,* August 2009, Available: http://www.kaiseredu.org/Issue-Modules/Primary-Care-Shortage/Background-Brief.aspx, Accessed October 21, 2010.
[21] Iglehart, John K. "Health Reform, Primary Care, and Graduate Medical Education," The New England Journal of Medicine, August 5, 2010, p585, Available: http://healthpolicyandreform.nejm.org/?p=3770, Accessed October 2010.
[22] Hobson, Katherine. "Solving the Med Student Debt Problem: Collect a Percentage of Income." The Wall Street Journal, July 6, 2010, Available: http://blogs.wsj.com/health/2010/07/06/solving-the-med-student-debt-problem-collect-a-percentage-of-income/, Accessed: October 21, 2010.
[23] Josiah Macy Jr. Foundation, *Who Will Provide Primary Care and How Will They be Trained?*, April 2010, p19, Available: http://www.josiahmacyfoundation.org/documents/JMF_PrimaryCare_Monograph.pdf, Accessed: October 21, 2010.
[24] Texas Higher Education Coordinating Board, *Funding Graduate Medical Education in Texas,* August 2004, page ii, Available: http://www.thecb.state.tx.us/reports/pdf/0778.pdf, Accessed: October 21, 2010.
[25] Iglehart, *supra* note 21.
[26] Association of American Medical Colleges. *Medicare Direct Graduate Medical Education (DGME) Payments*. Available: http://www.aamc.org/advocacy/library/gme/gme0001.htm, Accessed: October 21, 2010.
[27] Dr. Stacey Silverman, Texas Higher Education Coordinating Board, *Testimony before the Senate Committee on Health and Human Services*, (Austin, TX, February 23rd, 2010).
[28] Information provided by Health and Human Services Commission staff, May 25, 2010.
[29] Iglehart, *supra* note 21 at p584.
[30] Ortolon, Ken. "Losing the Match Game: Few Residency Slots Leave More Graduates Unmatched." Texas Medicine, August 2010, p43-45.

[31] Nightingale, Sarah. "Tech HSC gets federal support for fast track medical degree program." Lubbock Avalanche-Journal. October 5, 2010.
[32]Texas Tech University Health Sciences Center. (2010). *F-MAT Family Medicine Accelerated Track.* Available: http://www.ttuhsc.edu/som/fammed/fmat/fmathome.aspx, Accessed: August 9, 2010.
[33] Nightingale, *supra* note 31.
[34] Josiah Macy Jr. Foundation, *Who Will Provide Primary Care and How Will They be Trained?*, April 2010, Available: http://www.josiahmacyfoundation.org/documents/JMF_PrimaryCare_Monograph.pdf, Accessed October 21, 2010.
[35] American Association of Naturopathic Physicians. (2010). *What is Naturopathic Medicine?* Available: http://www.naturopathic.org/content.asp?pl=16&sl=59&contentid=59, Accessed: July 26, 2010.
[36] American Association of Naturopathic Physicians. (2010). *Licensed States and Licensing Authorities*. Available: http://www.naturopathic.org/content.asp?contentid=57, Accessed: July 26, 2010.
[37] Association of Accredited Naturopathic Medical Colleges. (2010). *How to Recognize a Quality Naturopathic Medical College.* Available: http://www.aanmc.org/education/recognizing-quality.php, Accessed: July 26, 2010.
[38] Texas Center for Nursing Workforce Studies, *The Supply of and Demand for Registered Nurses and Nurse Graduates in Texas,* November 2006, p1, Available: http://www.dshs.state.tx.us/chs/cnws/SB132rep.pdf, Accessed: October 21, 2010.
[39] Dr. Susan Sportsman, *supra* note 8.
[40] Paulette Burns, Texas Nursing Workforce Shortage Coalition, *Testimony before the Senate Finance Committee*, (Austin, TX, August 4, 2010).
[41]Texas Center for Nursing Workforce Studies, *Highlights: Texas Hospital Nurse Staffing Survey*, September 2006, Available: http://www.dshs.state.tx.us/chs/cnws/TXhosss.pdf, Accessed: October 21, 2010.
[42] National Council of State Boards of Nursing. *Transition to Practice: Promoting Public Safety.* Available: https://www.ncsbn.org/Transition_factsheet_final.pdf, Accessed: October 21, 2010.
[43] Kathy Thomas, *Presentation to Texas Hospital Association Leadership Conference*, (Austin, TX, February 2010).
[44] Dr. Alexia Green, Texas Team, *Testimony before the Senate Committee on Health and Human Services,* p3, (Austin, TX, February 23, 2010).
[45] *Id.* at p6.
[46] Paulette Burns, *supra* note 40.
[47] Dr. Stacey Silverman, Texas Higher Education Coordinating Board, *Testimony before the Senate Committee on Health and Human Services*, (Austin, TX, February 23, 2010).
[48] Regina, Bentley, Texas A&M Health Science Center, *Testimony before the Senate Finance Committee,* (Austin, TX, August 4, 2010).
[49] Katherine Thomas, *supra* note 43.
[50] Paulette Burns, *supra* note 40.
[51] Nielsen, Karen. "D-FW's RN Supply in Jeopardy." Dallas Business Journal, April 16, 2010.
[52] Dr. Douglas Murphy, Texas Society of Allied Health Professions, *Testimony before the Senate Committee on Health and Human Services*, p2-3, (Austin, TX, Feb 23, 2010).
[53] Dr. Douglas Murphy, Texas Society of Allied Health Professions, *Testimony before the Senate Committee on Health and Human* Services, (Austin, TX, February 23, 2010).
[54] Dr. Rick Black, Texas Dental Association, *Testimony before the Senate Committee on Health and Human Services*, (Austin, TX, February 23, 2010).
[55] *Id.*
[56] *Id.*
[57] Health Professions Resource Center, *Supply Trends Among Licensed Health Professions Texas, 1980-2009,* Available: http://www.dshs.state.tx.us/CHS/HPRC/09trends.pdf, Accessed: October 21, 2010.
[58] Becker, Emilie A., et al. "Shortage of Child and Adolescent Psychiatrists in Texas." March 2010.
[59] Information provided by Department of State Health Services staff, "Psychiatrist Shortage in the DSHS State Mental Health Hospital System," May 13, 2010.
[60] National Association of Social Workers - Texas Chapter. "Assuring the Sufficiency of a Social Worker Workforce for the Future of Texas." December 2009.
[61] Based on physicians actively billing Medicaid for services rendered.
[62] Data provided by Health and Human Services Commission staff, May 27, 2010.
[63] *Id.*

[64] Home and Community-Based Services Workforce Advisory Council, *Preliminary Workforce Recommendations Submitted to Thomas M. Suehs, Executive Commissioner Texas Health and Human Services Commission*, May 2010, p6.
[65] *Id.* at p7-8.
[66] Texas Medical Association, *Survey of Texas Physicians: Access to Care, Preliminary Research Findings 2010,* Available:http://www.texmed.org/uploadedFiles/Governmental_Affairs/March2010PreliminaryAccessCareReport.pdf, Accessed: October 21, 2010.
[67]Texas Medical Association News Release, "Texas Medical Residents Forced to Leave the State," September 22, 2010, Available: http://www.texmed.org/Template.aspx?id=9024, Accessed: October 21, 2010.
[68] Health and Human Services Commission, *HB 15 Frew Expenditure Plan*, September 2007, Available: http://www.hhsc.state.tx.us/medicaid/ExpenditurePlan_0907.pdf, Accessed: October 21, 2010.
[69] Health and Human Services Commission, *82nd Regular Session Legislative Appropriations Request, Exceptional Item Request Schedule, Version 1,* Available: http://www.hhsc.state.tx.us/LAR/2012-2013/Exceptiona-Item-Request-Schedule.pdf, Accessed: October 21, 2010.
[70] Department of State Health Services. (2010). *Texas Center for Nursing Workforce Studies.* Available: http://www.dshs.state.tx.us/chs/cnws/default.shtm, Accessed: October 21, 2010.
[71] Prepared by Health Professions Resource Center, Center for Health Statistics, Texas Department of State Health Services, October 20, 2009.
[72] Health Professions Resource Center, *supra* note 9 at p17.
[73] Dr. Karl Eschbach, *supra* note 1 at p20-25.
[74] Texas Medical Association, *Letter to State Leaders on Preserving Physician Medicaid Rates,* June 25, 2010, Available:http://www.texmed.org/uploadedFiles/Governmental_Affairs/Texas_Legislature/TMALtrstateleaders_PreserPhysMedicaidRates.pdf, Accessed October 21, 2010.
[75] Texas Occupations Code, Section 165.156.
[76]Veto statement by Governor Rick Perry, "Gov. Perry Vetoes HB 3485." June 19, 2009. Available: http://governor.state.tx.us/news/veto/12614/. Accessed: October 20, 2010.
[77] Becky Conditt, Texas Rural Health Association and Capital Area Health Education Center, *Testimony before the Senate Committee on Health and Human Services,* p5, (Austin, TX, February 23, 2010).
[78] Ramshaw, Emily. "No Country for Health Care, Part 2: The Trauma Hole." The Texas Tribune. January 5, 2010.
[79] Governor's EMS and Trauma Advisory Council, Rural Task Force, *Texas Elected Officials' Guide to Emergency Medical Services,* p7-19, Available: http://www.dshs.state.tx.us/emstraumasystems/TXEOG0405.pdf, Accessed: October 21, 2010.
[80] Department of State Health Services. (2010). *Federally Qualified Health Centers.* Available: http://www.dshs.state.tx.us/chpr/FQHCmain.shtm, Accessed: October 21, 2010.
[81] Health and Human Services Commission, *Telemedicine Medical Services in Texas Medicaid*, 2010, p1, Available: http://www.hhsc.state.tx.us/reports/2010/Telemedicine-Medical-Services-0910.pdf, Accessed: October 21, 2010.
[82] *Id.*at p4-5.
[83] The Office of the National Coordinator for Health Information Technology, "Help Wanted: Skilled Health IT Workforce to Modernize Health Care, A Message from Dr. David Blumenthal, National Coordinator for Health Information Technology," December 24, 2009, Available: http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__university_training__facts_at_a_glance/1430, Accessed: October 21, 2010.
[84] Id.
[85] The University of Texas at Austin. (2010). *Health Information Technology: What is Health IT and why is it a national priority?* Available: http://www.biosci.utexas.edu/healthit/, Accessed October 18, 2010.
[86] Lynda Woolbert, Coalition for Nurses in Advanced Practice, *Testimony before the Senate Committee on Health and Human Services,* p2-3, (Austin, TX, February 23, 2010).
[87] Naylor, Mary D. and Kurtzman, Ellen T. "The Role of Nurse Practitioners in Reinventing Primary Care." Health Affairs, May 2010, p893.
[88] Lynda Woolbert, *supra* note 86 at p30-38.
[89] *Id.* at p8.
[90] *Id.* at p9.
[91] *Id.* at p41-47.
[92] Prepared by Lynda Woolbert, Texas Coalition of Nurses in Advanced Practice, reviewed and edited by Texas Board of Nursing staff.

[93] Texas Medical Association. (2009). *Delegated Authority, Advance Practice Nurses, and Patient Safety*. Available: http://www.texmed.org/Template.aspx?id=7477, Accessed: October 21, 2010.

Interim Charge #6A: *Explore strategies to support the needs of aging Texans, including best practices in nursing home diversion, expediting access to community services, and programs to assist seniors and their families in navigating the long-term care system with the goal of helping seniors remain in the community.*

# Background

According to recent estimates, approximately 2.5 million individuals age 65 and older currently live in Texas.[1] By 2030, this number is projected to more than double, due in part to the aging baby boom generation, which includes individuals turning 65 in 2011.[2] Although relatively few individuals between ages 65 and 74 require long term services and supports,[3] the need for these services and supports increases substantially among individuals age 75 and older.[4] Coupling this with increasing life expectancies,[5] aging Texans' need for long term services and supports is expected to peak in fiscal year (FY) 2021, when the baby boom generation begins turning 75, and continue until at least 2050, when all the baby boomers are age 85 or older.[6] In light of this projected growth, it is imperative that aging Texans understand their long term care options and receive timely access to needed services and supports in order to maintain independence in their homes and communities.

Against the backdrop of a bourgeoning elderly population, the cost of long term care in Texas is also on the rise. Table 1 illustrates the increasing cost of care from FY 2005–2010 across various long term care settings.

**Table 1. Long Term Care Program Costs for Fiscal Years 2005–2010**[7]

| Provider | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|
| **Community Attendant Services** | $600 | $608 | $618 | $655 | $723 | $795 |
| **Primary Home Care** | $616 | $622 | $635 | $682 | $759 | $835 |
| **Day Activity and Health Services** | $470 | $477 | $481 | $497 | $508 | $526 |
| **Community Based Alternatives** | $1,302 | $1,293 | $1,286 | $1,380 | $1,456 | $1,568 |
| **Nursing Home** | $2,265 | $2,475 | $2,566 | $2,665 | $2,978 | $3,178 |

Although the cost of care across all long term care settings is trending upward, the cost of care in a nursing home remains exponentially higher than in a community based setting (e.g., client's home, adult day care, assisted living facility). For example, over 55,000 individuals currently receive services in a nursing home, at an average monthly cost of about $3,000.[8] However, individuals enrolled in the Medicaid Community Based Alternatives (CBA) waiver program receive services at an average monthly cost of $1,600, or about half the cost of nursing home care. The CBA waiver program is discussed in greater detail in the next section. In addition to community settings being less costly than nursing homes, they are also generally more appealing to elderly Texans.[9]

# Analysis

## I. Programs to Help Individuals Navigate the Long Term Care System

One of the greatest barriers individuals needing long term services and supports must overcome is not knowing what services are available or how to access them.[10] Currently, individuals, their family members and other caregivers may learn of available services and supports through a variety of sources, including physicians, 2-1-1 Texas,[11] the Internet (e.g., Your Texas Benefits[12]) and advertisements (e.g., brochures, bus signs).[13] The Department of Aging and Disability Services (DADS) provides a number of local resources aptly referred to as "front doors" that individuals may consult for help identifying and accessing long term services and supports. These "front doors" include DADS regional and local field offices, Area Agencies on Aging (AAAs) and local Mental Retardation Authorities (MRAs).[14] In addition to these resources, individuals in need of services can contact a local Aging and Disability Resource Center (ADRC), an entity designed to integrate DADS' front doors by providing consumers a "one stop shop" of information and services traditionally provided by several entities acting independently.

### *A. DADS' Front Doors*

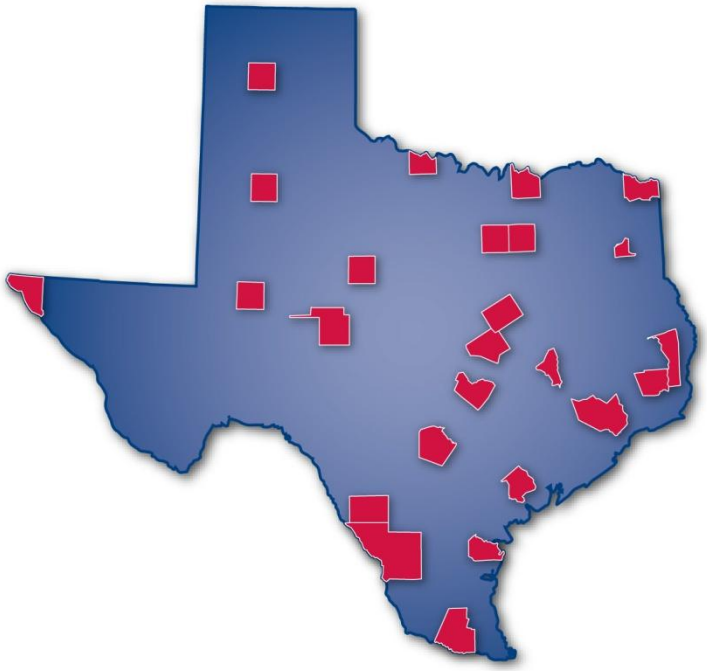
#### 1. DADS Regional and Local Field Offices[15]

DADS has nine regional headquarters and 186 field offices across Texas which manage the delivery of community services to seniors, individuals with disabilities, family members and other caregivers.[16] These offices help individuals interested in obtaining long term services and supports by completing assessments, determining their eligibility for services, helping them understand all of their options and, if needed, registering them on a Medicaid waiver program's interest list.[17] Medicaid waiver programs are discussed in greater detail in Charge #12.

#### 2. Area Agencies on Aging[18]

AAAs are quasi-governmental entities that provide information and services to individuals age 60 or older. Through contracts with DADS, a network of 28 AAAs provide services across Texas' 254 counties to seniors, their family members and other caregivers.[19] These services include information, referral and assistance; benefits counseling and legal assistance; care coordination; caregiver support services; in home support services and nutrition services.[20] AAA services are targeted to those with the greatest economic and social needs, including low income minorities, seniors living in rural areas, seniors with Alzheimer's disease and related disorders and seniors at risk of entering a nursing home.[21] In addition to providing information and services, AAAs also educate community partners and other organizations about available resources.[22] Figure 1 includes a map of Texas' 28 AAAs.

**Figure 1. Texas Area Agencies on Aging**[23]



3. Local Mental Retardation Authorities

Local MRAs serve as the point of entry for publicly funded programs serving individuals with intellectual and developmental disabilities.[24] Through contracts with DADS, 39 local MRAs provide community based services either directly or through a network of local providers.[25] These services include eligibility determinations, service coordination, community support, employment assistance, nursing and behavioral support, specialized therapies and vocational training.[26]

*B. Integrating the Front Door: DADS' Aging and Disability Resource Centers*

In 2005, under a three year grant from the U.S. Administration on Aging and the Centers for Medicare and Medicaid Services, DADS began establishing ADRCs to improve access to long term services and supports, help seniors and individuals with disabilities navigate the long term care system and make informed choices, and enable them to live independently in their own homes.[27] ADRCs are local projects established by community partners and are designed to eliminate the difficulty and frustration individuals experience when attempting to identify, and coordinate with, multiple entities to obtain the services they need. By bringing together all available community resources, ADRCs promote a "no wrong door" policy, serving as a direct access point to services through partnerships with DADS local offices, AAAs, MRAs, Medicaid eligibility offices, hospital discharge planners, Mental Health Authorities, independent living centers, local United Way agencies and other community organizations.[28] Currently, nine ADRCs are located in Texas (with two additional planned for FY 2010–2011). Figure 2 includes a map of the Texas counties these ADRCs serve.

**Figure 2. Counties Served by Texas Aging and Disability Resource Centers[29]**

ADRC partners may be "physically co-located," allowing consumers to go to one place for access to a variety of services.[30] Others are "virtually co-located," meaning community partners are connected through technology which enables them to electronically share information.[31] In addition to these models, some ADRC partners may be a hybrid of the two. ADRCs provide information as well as home care services, meals, transportation, benefits and prescription drug assistance, legal services, attendant services, respite or caregiver support and housing.[32] ADRC staff also help clients apply for Supplemental Security Income, SNAP food benefits, Medicare, Medicaid and other public benefits they may need.[33] Underscoring ADRCs' intention to serve as a "no wrong door" access point to services, ADRC staff are also cross trained on services and benefits that other community partners provide.[34]

In March 2009, the Health and Human Services Commission (HHSC) published an evaluation of Texas' ADRC program, which found that although consumers are generally satisfied with the ADRC services they received, their needs may surpass available community resources.[35] The evaluation also confirmed that there appears to be a great need for ADRC services and that this need will likely grow as the number of Texas' seniors increases.[36] DADS intends to establish a total of 20 ADRCs across the state by the year 2020.[37] For the next biennium, DADS' FY 2012–2013 Legislative Appropriations Request includes an Exceptional Item intended to continue funding existing ADRCs and to establish three additional ADRCs.[38] This Exceptional Item would require $3.7 million in General Revenue funds over the biennium.

Although ADRCs have been largely successful, they encounter continuous challenges including the need to increase their visibility and community partnerships.[39] ADRCs currently use local media, 2-1-1 Texas, print materials, Internet websites and email to raise awareness.[40] In addition, ADRCs are conducting targeted outreach to healthcare professionals and hospital and nursing home staff, as discussed in the next section.[41] To further increase community awareness of ADRCs, DADS could conduct additional outreach and marketing activities, including a media

campaign highlighting ADRCs as a resource offering a broad spectrum of services and access to community resources. In addition, DADS could establish community collaboratives with local senior centers, health fairs, drug stores and other entities. Finally, developing and maintaining additional community partnerships would also increase public awareness.

As mentioned previously, there are only 28 AAAs and nine ADRCs in Texas. Some ADRCs are exploring innovative strategies to serve individuals outside of the ADRC's geographic area. For example, the ADRC of Tarrant County is considering establishing a "mobile" ADRC.[42] Using a large recreational vehicle modified to house ADRC resources, a team would travel to special events, senior centers and health fairs to provide information and services to consumers in outlying areas.[43] To ensure that seniors and individuals with disabilities can easily access services even if they are not physically located near an AAA or ADRC, some advocates support HHSC and DADS developing a comprehensive, searchable online database containing up to date information about state, regional and local programs and licensed service providers. The state has already implemented a number of online initiatives to help seniors access long term services and supports, so it may be helpful to simply build on these existing resources.

C. *Single Point of Entry System*

To help seniors and their families navigate the long term care system and expedite access to needed services, a number of advocates would like Texas to establish a "single point of entry" system for long term services and supports. Similar to the ADRC model, staff would advise consumers about their options, determine their medical eligibility for services and tentatively determine their financial eligibility. However, unlike the ADRC model, staff would authorize services before an official eligibility determination has been made. This practice is termed "presumptive eligibility" and is intended to provide needed community services immediately to individuals who might otherwise enter a nursing home.

Nursing homes and home health agencies have the authority to provisionally deliver services based on a presumptive eligibility determination and either back bill Medicaid for services provided up to 90 days before eligibility was determined or assume the financial loss if the client is later found ineligible for services. Although nursing homes routinely do this, home health agencies generally do not. Instead of assuming any financial risk, a home health agency typically will not begin providing services until after an official eligibility determination has been made, a process which may take 30–45 days. As a result, an individual in crisis may begin receiving services immediately in a nursing home, whereas home health services may not be available for another 1-2 months. Some community care advocates believe this results in a "nursing home bias," due to individuals having the option to enter a nursing home immediately, instead of being required to wait 30–45 days to receive home health services.

During the 81st legislative session, SB 943 (Zaffirini) and HB 1398 (Guillen) attempted to establish a single point of entry pilot program in three areas at a cost of over $3 million in General Revenue funds, due primarily to individuals receiving services sooner than they otherwise would have. For the next biennium, DADS' FY 2012–2013 Legislative Appropriations Request includes an Exceptional Item intended to pilot a presumptive eligibility program in one region. This Exceptional Item would require $1.4 million in General Revenue funds over the biennium ($3.1 million All Funds) to establish the pilot program.[44]

Supporters of a single point of entry system believe it will generate substantial cost savings by diverting clients from more expensive nursing homes to less costly community settings. However, quantifying these potential savings is difficult, as this would require predicting how many individuals would have entered a nursing home instead of continuing to manage with informal supports (e.g., family, community faith based organizations). Going forward, it may be worthwhile to consider enhancing the existing ADRC model to include a presumptive eligibility component.

## II. Nursing Home Diversion Strategies

Although many of the resources discussed in the previous section also serve to divert seniors from nursing home placement, a number of other programs are specifically designed to identify seniors at imminent risk of nursing home placement and provide them with service options to help them remain at home and in their communities. These strategies include the Community Living Program and the Program of All-Inclusive Care for the Elderly (PACE). Additional nursing home diversion strategies which may be worthwhile include home telemonitoring, targeted Medicaid waiver slots, home delivered meals, improving personal attendant services in rural areas and building homes with accessible features.

### *A. DADS Community Living Program*

In 2008, DADS partnered with two ADRCs in Central Texas and Tarrant County and their local hospital systems to develop the Community Living Program designed to identify individuals (including veterans) who are not Medicaid eligible but are at imminent risk of nursing home placement and to provide service options to help them live independently in their homes and communities.[45] Using a specialized risk assessment tool, care transition specialists help hospital discharge planners identify individuals at risk of entering a nursing home following their hospital stay.[46] Once identified, the care transition specialist and ADRC staff help the family access services, create a monthly service plan and budget and, if needed, incorporate chronic disease self management interventions (e.g., diabetes management).[47] To advance this initiative, the ADRC of North Central Texas developed a "First Aid Kit" for hospital discharge planners, which includes a number of ADRC resources available in the community.[48] Using this kit, hospital staff can present patients with an array of choices as they transition from the hospital back to the community.[49]

The Community Living Program model is gaining momentum. The 2010 federal continuation grant for ADRCs now requires ADRCs to focus outreach to healthcare professionals and hospital and nursing home staff.[50] In addition, the U.S. Administration on Aging recently awarded DADS a $400,000 grant to expand the Community Living Program throughout Central Texas and mentor other ADRCs by:

- expanding access to services in the Central Texas region to a larger, more diverse group of older adults[51] and their family caregivers and implementing this program at a second hospital in Killeen, Texas;
- training Central Texas ADRC partner agencies to increase the number of qualified service providers; and
- conducting training workshops for all ADRCs in Texas, including best practice strategies and tools for implementation.[52]

As of October 2010, the two ADRCs in Central Texas and Tarrant County and their local hospital systems have served almost 300 individuals through the Community Living Program.[53]

*B. Program of All-Inclusive Care for the Elderly (PACE)*

PACE provides community based services in El Paso, Lubbock and Amarillo to individuals age 55 or older who qualify for nursing home placement.[54] Under the PACE model, clients are transported to an adult day care center where onsite medical staff provide needed services. If a client requires services the adult day care center is unable to provide, staff will transport the client to another healthcare provider to receive services. PACE services include inpatient and outpatient medical care, specialty services (e.g., dentistry, podiatry), social services, in home care, meals, transportation, day activity and housing assistance. PACE providers are paid a capitated monthly fee below the cost of comparable nursing home care.[55] In FY 2009, almost 900 individuals received services each month through PACE at an average monthly cost of $2,800 (almost $400 less than the average monthly cost of nursing home care).[56] For the next biennium, DADS' FY 2012–2013 Legislative Appropriations Request includes an Exceptional Item intended to fund 150 additional slots for existing PACE program sites and fund two additional sites with 200 slots each.[57] This Exceptional Item would require $6.9 million in General Revenue funds ($17.6 million in All Funds) over the biennium.[58]

*C. Home Telemonitoring*

To prevent unnecessary hospitalizations and nursing home placement, a number of community care advocates support creating a Medicaid home telemonitoring benefit both in Medicaid community based entitlement programs and waiver programs targeted to individuals who struggle to manage their chronic conditions. This telemonitoring system would transmit health data (e.g., client's weight, vital signs, blood sugar) to the home health agency without the need for a personal attendant to be present in the client's home. An agency nurse would review the data and, if needed, work with a physician to modify the client's medication or treatment regimen and determine whether additional client education and/or attendant visits are necessary.[59] During the 81st legislative session, SB 1769 (Watson) and HB 3234 (Davis) attempted to create a Medicaid home telemonitoring benefit. These bills were cost neutral and provided that any additional service costs would likely be offset by savings in client services as a result of avoiding more costly care.

*D. Medicaid 1915(c) Waiver Programs*

1. Community Based Alternatives Waiver Program

The Community Based Alternatives (CBA) waiver program provides home and community based services for individuals who are elderly or disabled, as an alternative to nursing home care.[60] The 81st Legislature funded almost 200 HCS waiver slots for individuals with intellectual and developmental disabilities who are at imminent risk of institutional placement, and some advocates believe similar measures should be taken for individuals who are elderly or disabled and are at imminent risk of nursing home placement. Currently, individuals already in a nursing home can access waiver services within about 90 days.[61] However, once in a nursing home, these individuals may lose their assets and informal supports, making it much more difficult to return to the community.

For the next biennium, DADS' FY 2012–2013 Legislative Appropriations Request includes an Exceptional Item to fund 100 CBA waiver slots for individuals at imminent risk of nursing home placement.[62] This Exceptional Item would require $750,000 in General Revenue funds ($1.9 million in All Funds) over the biennium.[63] In addition, HHSC and DADS could target outreach to individuals at imminent risk of nursing home placement and offer eligible individuals Medicaid community based entitlement services (e.g., Primary Home Care, Community Attendant Services) while they are on the CBA interest list.

2. Home and Community-based Services (HCS) Waiver Program

The Home and Community-based Services (HCS) waiver program provides individualized services and supports to individuals of all ages with an intellectual or developmental disability who live in their family's home, their own home, or another community setting (e.g., a small group home).[64] Individuals under age 22 who are living in a nursing home can immediately transfer into the HCS program.[65] However, adults over age 22 must register on the HCS waiver program's interest list (which is maintained on a first come, first served basis) and wait for a waiver slot to become available.[66] Some advocates believe DADS should seek an amendment to the HCS waiver allowing adults with intellectual and developmental disabilities who live in a nursing home or are at imminent risk of nursing home placement to access the HCS waiver.

*E. Medicaid Entitlement Programs*

1. Intermediate Care Facilities for Individuals with Mental Retardation (ICFs/MR)

If an ICF/MR provider determines a client's needs have changed and the client can no longer benefit from active treatment at the facility or the facility can no longer meet the client's health and safety needs, the provider must help the individual find an alternate placement.[67] This alternate placement may include a nursing home if the individual is eligible for nursing home services. Some disabilities advocates would like DADS to prevent ICF/MR clients from later being placed in a nursing home. However, eliminating nursing homes as an available placement option may jeopardize the client's health and safety, result in more hospitalizations or cause ICF/MR providers to no longer serve individuals with significant medical needs.[68] Table 2 includes information about the number of individuals who moved from ICFs/MR to a nursing home from FY 2005–2010.

**Table 2. Individuals Moving from an ICF/MR to a Nursing Home[69]**

| Fiscal Year | Move in 1 day or less | Move in 5 days or less | Move in 30 days or less | Total moves |
|---|---|---|---|---|
| 2005 | 163 | 193 | 251 | **404** |
| 2006 | 155 | 174 | 230 | **370** |
| 2007 | 115 | 137 | 177 | **308** |
| 2008 | 98 | 122 | 150 | **258** |
| 2009 | 77 | 85 | 112 | **191** |
| 2010* | 43 | 50 | 62 | **94** |

*Partial year

To ensure that individuals are aware of alternatives to nursing home placement and prevent nursing home admission, DADS and HHSC are currently revising the Texas Preadmission Screening and Resident Review process to require certain assessments to be conducted prior to an individual entering a nursing home.[70]

*F. Home Delivered Meals*

Historically, home delivered meal programs were funded by DADS, local AAAs and private donations. However, as the elderly and disabled population increased, new funding sources were needed to meet increasing needs.[71] The 80th Legislature created the Texas Department of Agriculture's Texans Feeding Texans: Home Delivered Meal Grant Program to provide additional funding to certain home delivered meal providers.[72] The Meals on Wheels Association of Texas estimates that these services prevent or delay at least 10% of the agency's clients from entering a nursing home, potentially saving millions in taxpayer dollars each year.

*G. Personal Attendant Services in Rural Areas*

DADS provides seniors in-home personal attendant services (e.g., assistance with meal preparation, bathing, dressing, grooming) primarily through the CBA waiver program and the Primary Home Care (PHC) and Community Attendant Services (CAS) Medicaid entitlement programs.[73] These personal attendant services are available statewide. However, ensuring that seniors living in rural areas with few providers can access these services can be challenging. First, PHC and CAS providers are not reimbursed for travel, so it costs more for them to serve individuals in remote areas.[74] As a result, a provider may determine it is not cost effective for a personal attendant to travel long distances for a two to three hour shift. Instead, the attendant may provide "consolidated" services, delivering services all day, once or twice per week instead of providing services for a few hours each day. Although clients requiring daily assistance may still receive the same amount of services each week, their daily needs will remain unmet.

Providing in-home services to rural clients enrolled in the CBA waiver program can also be a challenge. In order to be eligible for the CBA waiver, an individual must require daily or regular skilled nursing. CBA clients living in rural areas and requiring nursing interventions may encounter barriers to accessing needed services due to nursing shortages in these areas.[75] In addition, providers may refuse to accept clients requiring ongoing nursing services because they are simply unable to meet their needs. Nursing shortages are discussed in greater detail in Interim Charge #5.

PHC, CAS and CBA providers are eligible to participate in attendant compensation rate enhancement, an initiative HHSC developed to incentivize providers to increase personal attendants' compensation.[76] Under this program, providers who agree to spend 90% of their total attendant revenues on attendant compensation (e.g., salaries, payroll taxes, benefits, mileage reimbursement) are eligible for a higher reimbursement rate. As of September 2010, 82% of PHC and CAS providers and 80% of CBA providers participated in this program.[77] In addition to attendant compensation rate enhancement, HHSC could consider providing other monetary incentives for rural providers. Alternatively, DADS could require providers under contract with DADS to serve all counties within the contracted region. Currently, providers may choose which counties to serve within a DADS region.[78]

*H. Building Homes with Accessible Home Features*

To ensure that seniors with mobility impairments can live independently in their own homes, community care advocates would like community development corporations to build homes with specific features that make the home easier for individuals with mobility impairments to maneuver. These features may include widened doors, a zero step entrance, and accessible

kitchens and bathrooms.[79] Advocates believe building homes with this "barrier free" design may result in substantial cost savings due to more seniors delaying or entirely avoiding nursing home placement. Currently, some city ordinances require homes built with public funds to have a visitable, barrier free design.[80]

According to a 2008 survey conducted in accordance with DADS' 2009 Aging Texas Well report, most homes of the seniors surveyed included some accessible features (see Table 3). However, the report also found that 14% of Texans age 60 and older reported that their home's doorways, hallways, kitchen, bathrooms, and closets needed substantial modification to make it easier to get around inside. Thirty-eight percent of older Texans did not know where to go for help in making these types of home modifications.

**Table 3. Homes with Accessible Features[81]**

| Does your home have….? (all that apply) | Percent of respondents |
|---|---|
| Reachable light switches/thermostats, electrical outlets | 76% |
| Accessible interior walkways (wide interior doorways/hallways) | 69% |
| An accessible entrance (no-step or ramp, wide door) | 63% |
| Kitchen layout with open floor space, removable cabinets etc | 54% |
| Bath layout with open space, shower, grab bars, low cabinets | 49% |
| Features that would accommodate visual/hearing impairments | 26% |

### III. Expediting Access to Community Services

As previously discussed, increasing public awareness of resources such as AAAs and ADRCs should expedite consumers' access to community services. In addition, HHSC and DADS should commission a study to identify the circumstances under which an individual may enter a nursing home, what services the individual has received, where services were provided and by whom, what community supports are currently available and how to expedite access to services for which the individual would be eligible but for which an interest list exists. This study could provide valuable recommendations to improve service delivery and enable more individuals to receive needed supports while remaining in their homes and communities.

## Recommendations

1. **Direct the Health and Human Services Commission and the Department of Aging and Disability Services to conduct a study to determine how individuals arrive at a nursing facility's "front door," what services the individual has received, where services were provided and by who, what community supports are currently available and how to expedite access to services for which the individual would be eligible but for which an interest list exists.**

[1] Texas Department of Aging and Disability Services Reference Guide 2010, p. 96 (hereinafter termed "DADS 2010 Reference Guide"). Available online at

http://cfoweb.bdm.dhs.state.tx.us/ReferenceGuide/guides/FY10ReferenceGuide.pdf (Last accessed November 11, 2010).

[2] U.S. Department of Health and Human Services, Administration on Aging, "Projected Future Growth of Older Population," available online at http://www.aoa.gov/AoARoot/Aging_Statistics/future_growth/future_growth.aspx#state (Last accessed November 11, 2010).

[3] "Long term services and supports" is defined as assistance for persons who are elderly and those with chronic disabilities. The goal of long-term services and supports is to help individuals be as independent as possible. These services and supports may include assistance with "activities of daily living," or activities essential to daily personal care including bathing or showering, dressing, getting in or out of bed or a chair, using a toilet, and eating. *See* Texas Medicaid and CHIP in Perspective, Seventh Edition, Texas Health and Human Services Commission, January 2009, Glossary.

[4] The Policy Book: AARP Public Policies 2009–2010, Chapter 8, p. 1. (hereinafter termed "AARP Policy Book 2009–2010"). Available online at http://assets.aarp.org/www.aarp.org_/articles/legpolicy/2008/Chapter8.pdf (Last accessed November 10, 2010).

[5] According to the U.S. Department of Health and Human Services Centers for Disease Control and Prevention's report titled "Health, United States, 2008," overall death rates have declined and life expectancy shows a long term upward trend. Available online at http://www.cdc.gov/nchs/data/hus/hus08.pdf#026 (Last accessed July 23, 2010).

[6] Department of Aging and Disability Services Presentation to the Senate Committee on Finance, July 7, 2010, slide 4 (hereinafter termed "DADS Senate Finance Presentation"). Available online at: http://www.dads.state.tx.us/news_info/presentations/SenateFinance-7-7-10.pdf (Last accessed July 22, 2010). *See also* AARP Policy Book 2009–2010, Chapter 8, p. 1.

[7] Information provided by DADS via email dated November 15, 2010. According to DADS, the relatively large increases from FY 2007–2010 for the Community Care entitlement programs and the CBA waiver program are due in large part to the annual increases in the federal minimum wage in July 2007, July 2008, and July 2009 respectively, and are not indicative of continuing cost trends in those programs.

[8] DADS Senate Finance Presentation, slide 9.

[9] AARP Policy Book 2009–2010, Chapter 8, p. 2.

[10] According to a recent DADS Aging Texas Well Report, only one third of older Texans surveyed in 2008 had heard about DADS' Area Agency on Aging programs. *See* Aging Texas Well Indicators Survey Overview Report 2009, Texas Department of Aging and Disability Services Center for Policy and Innovation, April 2009, p. vi (hereinafter termed "Aging Texas Well 2009 Report"). Available online at http://www.dads.state.tx.us/news_info/publications/studies/ATWindicators2009.pdf (Last accessed November 10, 2010).

[11] Additional information about 2-1-1 Texas is available online at https://www.211texas.org/211/.

[12] Your Texas Benefits is provides secure access to HHSC benefits including Medicaid, Food Stamps, Temporary Assistance for Needy Families, Children's Health Insurance Program, nursing home care and other services for seniors and individuals with disabilities. Individuals can complete a screening assessment to determine programs they may qualify for and apply for benefits online. Additional information about Your Texas Benefits is available online at https://www.yourtexasbenefits.com/wps/portal.

[13] Department of Aging and Disability Services Presentation to the Senate Committee on Health and Human Services, May 12, 2010, slide 3 (hereinafter termed "DADS Senate HHS Presentation"). Available online at: http://www.dads.state.tx.us/news_info/presentations/SHHS-aging-5-12-10.pdf (Last accessed November 10, 2010).

[14] Most MRAs are also Mental Health Authorities and all but one are community mental health and mental retardation centers. *See* "Access and Intake Services Community Options Booklet," Texas Department of Aging and Disability Services, p. 2 (hereinafter termed "DADS Access and Intake Booklet"). Available online at www.dads.state.tx.us/providers/community_options.pdf (Last accessed November 15, 2010).

[15] Additional information about DADS' local offices is available online at http://www.dads.state.tx.us/services/contact.cfm (Last accessed November 10, 2010).

[16] DADS Senate HHS Presentation, slide 4.

[17] Information provided by DADS via email dated May 24, 2010.

[18] Additional information about DADS' Area Agencies on Aging is available online at http://www.dads.state.tx.us/providers/AAA/index.html.

[19] "DADS Access and Intake Booklet," p. 1. *See also* DADS Senate HHS Presentation, slide 4. Family members and other caregivers may receive information and services on behalf of the senior for whom they are providing care.

[20] *See* "Area Agencies on Aging," Texas Department of Aging and Disability Services. Available online at http://www.dads.state.tx.us/providers/AAA/index.html (Last accessed November 10, 2010). For additional information about what each of these services entail, see "Area Agencies on Aging Covered Services." Available online at http://www.dads.state.tx.us/services/faqs-fact/aaa.html (Last accessed November 10, 2010). *See also* DADS Access and Intake Booklet, pp. 66–77.
[21] *Id. See also* DADS Access and Intake Booklet, p. 67.
[22] Information provided by DADS via email dated June 10, 2010.
[23] AAA map provided by DADS via email dated November 15, 2010.
[24] DADS Access and Intake Booklet, p. 78.
[25] DADS Senate HHS Presentation, slide 4.
[26] *Id.* at p. 2.
[27] Information provided by DADS via email dated June 14, 2010. *See also* "Aging and Disability Resource Centers (ADRCs)," Texas Department of Aging and Disability Services. Available online at http://www.dads.state.tx.us/news_info/improvingaccess/adrc/index.html (Last accessed November 17, 2010).
[28] DADS Senate HHS Presentation, slide 6. *See also* "ADRCs rely on partnerships," Texas Department of Aging and Disability Services. Available online at http://www.dads.state.tx.us/news_info/improvingaccess/adrc/partnerships.html (Last accessed November 10, 2010).
[29] ADRC map available on DADS' website at http://www.dads.state.tx.us/services/adrc/locations.html (Last accessed November 11, 2010).
[30] *See* "How ADRCs work," Texas Department of Aging and Disability Services. Available online at http://www.dads.state.tx.us/news_info/improvingaccess/adrc/howitworks.html (Last accessed November 10, 2010).
[31] *See* "Aging and Disability Resource Centers (ADRCs)," Texas Department of Aging and Disability Services. Available online at http://www.dads.state.tx.us/news_info/improvingaccess/adrc/index.html (Last accessed November 10, 2010). *See also* DADS Senate HHS Presentation, slide 6.
[32] *Id.*
[33] *See* "What services are offered?," Texas Department of Aging and Disability Services. Available online at http://www.dads.state.tx.us/services/adrc/services.html (Last accessed November 10, 2010).
[34] *See* "How ADRCs work," Texas Department of Aging and Disability Services. Available online at http://www.dads.state.tx.us/news_info/improvingaccess/adrc/howitworks.html (Last accessed November 10, 2010).
[35] Information provided by DADS via email dated June 14, 2010.
[36] Texas Aging and Disability Resource Center Evaluation, Health and Human Services Commission, March 2009, p. 3.
[37] DADS Senate HHS Presentation, slide 7.
[38] DADS Presentation to the Legislative Budget Board and the Governor's Office of Budget, Planning and Policy, September 16, 2010, slide 12 (hereinafter termed "DADS Joint Budget Hearing Presentation"). Available online at http://www.dads.state.tx.us/news_info/presentations/LBBGOBPP-9-16-10pdf.pdf (Last accessed November 11, 2010).
[39] Information provided by DADS via email dated June 14, 2010.
[40] Information provided by DADS via email dated June 10, 2010. In accordance with the federal/state grant initiative, DADS is required to include media and outreach activities to publicize how individuals can connect to long term services and supports.
[41] Information provided by DADS via email dated June 10, 2010.
[42] Information provided by DADS via email dated July 9, 2010.
[43] *Id.*
[44] Information provided by DADS via email dated October 5, 2010.
[45] DADS Senate HHS Presentation, slides 11–12.
[46] *Id.* at slide 12.
[47] *Id.* at slide 13.
[48] Information provided by DADS via email dated July 9, 2010.
[49] *Id.*
[50] Information provided by DADS via email dated July 9, 2010.
[51] This population may include individuals under age 60, with chronic conditions such as dementia, diabetes, heart disease, chronic obstructive pulmonary disorder, arthritis, and/or multiple complex needs. *See* "The Texas ADRC Evidence-Based Care Transition Program," Submitted to the U.S. Administration on Aging by the Texas Department of Aging and Disability Services, July 2010, p. 5.

[52] "The Texas ADRC Evidence-Based Care Transition Program," Submitted to the U.S. Administration on Aging by the Texas Department of Aging and Disability Services, July 2010, p. 1. Follow up information provided by DADS via email dated November 12, 2010.
[53] Information provided by DADS via email dated November 12, 2010.
[54] DADS Access and Intake Booklet, p. 57. As of December 31, 2009, 8% of individuals receiving PACE services were under age 65 and 92% were age 65 or older.
[55] *Id.*
[56] DADS 2010 Reference Guide, p. 66.
[57] DADS Presentation to the Legislative Budget Board and the Governor's Office of Budget, Planning and Policy, September 16, 2010, slide 18 (hereinafter termed "DADS Joint Budget Hearing Presentation"). Available online at http://www.dads.state.tx.us/news_info/presentations/LBBGOBPP-9-16-10pdf.pdf (Last accessed November 11, 2010).
[58] *Id.*
[59] *See* Texas Association for Home Care & Hospice presentation to the Senate Committee on Health and Human Services , May 12, 2010, slide 12. Available online at http://www.senate.state.tx.us/75r/senate/commit/c610/h2010/512-AnitaBradberry.pdf (Last accessed November 11, 2010).
[60] DADS Access and Intake Booklet, p. 11.
[61] Information provided by DADS via email dated June 10, 2010.
[62] DADS Presentation to the Legislative Budget Board and the Governor's Office of Budget, Planning and Policy, September 16, 2010, slide 11 (hereinafter termed "DADS Joint Budget Hearing Presentation"). Available online at http://www.dads.state.tx.us/news_info/presentations/LBBGOBPP-9-16-10pdf.pdf (Last accessed November 11, 2010).
[63] Information provided by DADS via email dated November 12, 2010.
[64] DADS Access and Intake Booklet, p. 82.
[65] Information provided by DADS via email dated June 10, 2010.
[66] *Id.*
[67] Information provided by DADS via email dated June 10, 2010 and October 18, 2010.
[68] Information provided by DADS via email dated June 10, 2010.
[69] Table prepared by DADS.
[70] Information provided by DADS via email dated June 10, 2010.
[71] HB 407 Bill Analysis, April 5, 2007. Available online at http://www.capitol.state.tx.us/tlodocs/80R/analysis/pdf/HB00407E.pdf#navpanes=0 (Last accessed November 11, 2010).
[72] HB 407 (Chisum et al./Watson).
[73] Information provided by DADS via email dated June 10, 2010.
[74] *Id.*
[75] *Id.*
[76] *See* "Attendant Compensation Rate Enhancement," Health and Human Services Commission, July 2010. Available online at http://www.hhsc.state.tx.us/medicaid/programs/rad/Enhance/2011CcNfTrngHandout.pdf (Last accessed November 11, 2010). *See also* 1 Tex. Admin. Code §355.112.
[77] Information provided by DADS via email dated November 12, 2010.
[78] Information provided by DADS via email dated June 10, 2010.
[79] AARP Policy Book 2009–2010, Chapter 9, p. 27. Available online at http://assets.aarp.org/www.aarp.org_/articles/legpolicy/2008/Chapter9.pdf (Last accessed November 12, 2010).
[80] Texas Catholic Conference Testimony to the Senate Committee on Health and Human Services, May 12, 2010.
[81] Aging Texas Well 2009 Report, p. 55.

Interim Charge #6B: *Study the guardianship program implemented by the Department of Aging and Disabilities and the Department of Adult Protective Services, including the efficiency and effectiveness of the program, the relationship between the two agencies, the appropriate rights for parents, and whether clients and their assets are adequately protected to ensure the state is appropriately indentifying seniors in need of protection.*

# Background

Guardianship is a legal arrangement designed to protect individuals who are incapacitated.[1] Under Texas law, an individual lacks capacity if a physical or mental condition renders the individual "substantially unable to provide food, clothing, or shelter for himself or herself, to care for the individual's own physical health, or to manage the individual's own financial affairs."[2] An incapacitated individual placed in guardianship is referred to as a ward and the court appointed individual or entity who makes decisions on behalf of the ward is referred to as a guardian.[3]

If a probate court determines a guardianship is needed, the court may appoint a guardian with either limited or full authority over a ward, depending on the ward's physical or mental limitations.[4] In addition, a court may appoint an individual or entity to serve as the guardian of the person, guardian of the estate, or both.[5] Table 1 includes a list of powers and duties of both guardians of the person and guardians of the estate.

**Table 1. Powers and Duties of Guardians of the Person and Guardians of the Estate**

| Guardian of the Person | Guardian of the Estate |
|---|---|
| • Right to have physical possession of the ward and to establish the ward's legal domicile;<br>• Duty to provide care, supervision and protection for the ward;<br>• Duty to provide clothing, food, medical care and shelter for the ward;<br>• Power to consent to medical, psychiatric and surgical treatment other than inpatient psychiatric commitment of the ward; and<br>• Power to establish a trust and direct that the ward's income be paid directly to the trust upon order of the court.[6] | • Right to possess and manage all property belonging to the ward and collect all debts, rentals or claims due to the ward;<br>• Right to enforce all obligations in favor of the ward and bring and defend suits by or against the ward;<br>• Duty to take care of and manage the ward's estate, as a prudent person would manage the person's own property; and<br>• Duty to account for all rents, profits and revenues the estate would have produced by such prudent management.[7] |

A number of individuals and entities may serve as an incapacitated person's guardian, including a family member or friend, private professional guardian, private guardianship program, county operated guardianship program, or the Department of Aging and Disability Services' (DADS) Guardianship Services Program.[8] This report focuses primarily on guardianships of incapacitated individuals the Department of Family and Protective Services (DFPS) refers to DADS in connection with a finding of abuse, neglect or exploitation of the incapacitated individual.[9]

# Analysis

DFPS administered Texas' Guardianship Services Program until December 2004 when it was transferred to DADS.[10] Guardianships under DADS' Guardianship Services Program are a relatively small subset of all Texas guardianships. According to the Office of Court Administration, as of June 2010, there were almost 40,000 active guardianships in Texas' 10 largest counties alone. Of these, only 1,232 were administered by DADS' Guardianship Services Program. In the near future, the Office of Court Administration will begin collecting data regarding active guardianships in *all* Texas counties, which should enable a better understanding of the percentage of active guardianships administered by DADS.[11]

**Relationship Between DFPS and DADS**

DFPS and DADS work together to identify victims of abuse, neglect or exploitation who are in need of guardianship services. Generally, DFPS investigates allegations of abuse, neglect or exploitation of elderly or disabled individuals and refers individuals to DADS' Guardianship Services Program if:

- the individual is in an ongoing state of abuse, neglect[12] or exploitation and is at risk of further harm;
- DFPS has reason to believe the individual is incapacitated; and
- less restrictive alternatives (e.g., family, friends, other social services) are inadequate to protect the individual.[13]

*DFPS Referrals to DADS Guardianship Services Program*

Before determining whether an individual should be referred to DADS for guardianship services, DFPS will:

- complete an investigation and assessment of the client, identifying possible indicators of incapacity based on observing the client's behavior, degree of impairment and living conditions, and evidence of diminished capacity to consent to or refuse services;
- determine if the client is at risk of abuse, neglect or exploitation and if the client's support system is adequate to keep the client safe;
- explore all less restrictive alternatives to DADS' Guardianship Services Program (including family, friends and others willing to serve as the individual's guardian);
- confirm that the client has financial resources or is eligible for benefits to provide for the client's care;[14] and
- make a formal determination that guardianship will resolve all or some of the problems and will serve to protect the client.[15]

If DFPS determines an individual should be referred to DADS' Guardianship Services Program, DFPS will submit a Guardianship Referral Form to DADS.[16] The referral form outlines the problems a guardianship will address, provides information regarding less restrictive alternatives and alternate guardians DFPS explored and provides any other relevant information to assist with DADS' guardianship assessment.[17]

*Ongoing Collaboration Between DADS and DFPS*

After submitting the referral form to DADS, DFPS will send DADS any new information DFPS receives , including information obtained from a medical or mental health assessment.[18] In

addition, DFPS will continue investigating any remaining allegations of abuse, neglect or exploitation and will provide protective services[19] as needed to ensure the client's safety until DADS can complete its assessment and determine whether the client is appropriate for guardianship. Table 2 includes the number of referrals DFPS submitted to DADS' Guardianship Services Program in fiscal year (FY) 2010 and DADS' disposition of these referrals.

**Table 2. DFPS Referrals to DADS Guardianship Services Program - FY 2010[20]**

| DADS' Disposition of Referrals | Number of Referrals |
|---|---|
| DADS applied for guardianship | 183 |
| Identified, arranged or recommended less restrictive alternative | 70 |
| Determined ward has capacity/no guardianship recommendation | 34 |
| Referred to private guardianship program or guardian | 1 |
| Not appropriate/guardianship will not resolve problems | 38 |
| Identified alternate guardian | 40 |
| Not appropriate/mental health only | 14 |
| Unable to assess/withdrawn by DFPS or client died | 18 |
| No funds/benefits | 4 |
| **Total** | **402** |

In the event that DADS believes guardianship is not appropriate, the department will provide written notification to DFPS including any issues guardianship will not resolve (e.g., inability to prevent client who lives in the community from continuing to abuse drugs which was the basis of DFPS' referral; ward incarcerated for extended periods of time in state or federal penal institution).[21] If DFPS agrees with DADS' decision not to seek guardianship, DFPS must attempt to identify a stable living arrangement for the individual. Alternatively, if DFPS disagrees with DADS' decision not to seek guardianship, the agencies will conduct a joint meeting at the local level to seek resolution. If the disagreement cannot be resolved during this meeting, DFPS may appeal DADS' decision to the DADS' Regional Operations Manager.[22] In FY 2010, DFPS requested only eight reviews of DADS' decision not to pursue guardianship.[23] Five were reversed and DADS applied for guardianship, two were upheld by the review and one is still pending.[24]

*DADS Guardianship Services Program*

When all less restrictive alternatives to guardianship have been exhausted and no other guardian can be found, DADS' Guardianship Services Program may provide guardianship services to individuals DFPS referred to DADS, either directly or through contracts with local guardianship programs.[25] Once DFPS submits a referral to DADS' Guardianship Services Program, DADS must conduct a thorough assessment of the individual's conditions and circumstances in order to determine whether guardianship is appropriate or whether a less restrictive alternative is available.[26] When conducting this assessment, DADS will:

- ask the proposed ward questions intended to determine whether he/she appears to have diminished capacity;
- consult with DFPS, medical providers and others with knowledge of the proposed ward;
- evaluate the proposed ward's living conditions; finances; factors causing abuse, neglect or exploitation and possible solutions to resolve these conditions (including less restrictive alternatives and alternate guardians[27]); medical conditions, records and medications; and

- obtain a Certificate of Medical Examination if a less restrictive alternative or alternate guardian is not available.[28]

If DADS determines guardianship is appropriate, DADS must file an application with the probate court to be appointed guardian of the person, guardian of the estate, or both.[29] DADS must file this application within 70 days of receiving DFPS' referral.[30] However, if needed, DADS may extend this period by up to 30 days with DFPS' approval.[31] After the application is filed, the probate court must determine whether the individual lacks capacity. If so, the court must determine whether to grant DADS temporary or permanent guardianship of the person, estate or both.[32]

*Efficiency and Effectiveness of DADS' Guardianship Services Program*
DADS and DFPS have worked to streamline their processes and eliminate inefficiencies. For example, the agencies are developing an automation project to enable the electronic transfer of guardianship referrals from DFPS to DADS.[33] This project is scheduled for completion by December 2010.[34] Also, in accordance with a Memorandum of Understanding between DADS and DFPS, the agencies conduct quarterly Interagency Steering Committee meetings to address any issues or concerns which may impact either agency's ability to effectively deliver services.[35]

Notwithstanding these efforts, DADS and DFPS appear to have very similar processes for determining whether guardianship is appropriate. For example, both agencies conduct assessments of the individual to identify possible indicators of incapacity, explore less restrictive alternatives to guardianship and attempt to locate family, friends and others willing and able to serve as the individual's guardian. While some duplicative efforts may be necessary to protect the proposed ward and ensure that individuals are not inappropriately placed in guardianship, DADS and DFPS should continue exploring opportunities to further streamline this process and prevent any unnecessary duplication of efforts between the agencies. To that end, the Interagency Steering Committee is currently evaluating the agencies' shared responsibility to locate less restrictive alternatives to guardianship as a potential area of duplicative effort.[36] DADS and DFPS will jointly analyze their current policies, procedures and best practices to further streamline this function.[37]

**Protecting Wards and Their Assets**
To ensure that wards and their assets are adequately protected, probate courts annually review guardianships and require guardians of the person and guardians of the estate to submit annual reports to the court. Probate courts must also approve all significant expenditures exceeding the monthly allowance authorized by the court. Finally, DADS' Guardianship Services Program also reviews guardianships; conducts quality assurance and monitoring visits and complaint investigations; and establishes rules, standards and procedures for contracted guardianship providers and DADS' Guardianship Services Program staff.[38]

*Protecting Wards: Probate Court Review of Ward's Capacity*
In order to ensure that wards are adequately protected, probate courts annually review each guardianship under the court's jurisdiction to determine whether the guardianship should be continued, modified or terminated.[39] In addition, under Texas law, a ward or anyone interested in the ward's welfare may petition the court to modify or terminate a guardianship when the

ward's capacity is partially or completely restored.[40] However, courts generally prohibit individuals from seeking modification or termination of a guardianship within the first year of the guardianship being in effect.[41]

*Guardian's Annual Reports to the Probate Court*
Probate courts also require guardians of the person to submit an annual report to the court,[42] including the previous year's receipts and expenditures for the ward's support, maintenance and education;[43] information from the previous year about the ward's living arrangements, physical and mental health, medical care, and educational, recreational, social and occupational activities; visits with the ward; and an evaluation of the ward's circumstances and ongoing needs.[44] Probate courts also require guardians of the estate to submit an annual accounting of financial management to the court, including a list of all claims against the estate; whether they were allowed, paid or rejected; and any changes in the estate's assets.[45]

*Protecting Wards' Assets: Probate Court Approval for all Significant Expenditures*
If a guardian expends funds from the ward's estate for the ward's support and maintenance and the expenditures exceed the monthly allowance authorized by the court, the guardian must file a motion with the court requesting approval of the expenditures.[46] The court may approve the excess expenditures if:

- the expenditures were reasonable and proper and were made when it was not convenient or possible for the guardian to obtain the court's approval;
- the court would have granted the guardian advance authority to make the expenditures; and
- the ward received the benefits of the expenditures.[47]

As an additional measure to ensure that wards' assets are adequately protected, DFPS should alert law enforcement after removing a proposed ward from his/her home in accordance with an emergency order authorizing protective services, if the proposed ward's home is left vacant. Once a proposed ward is removed from his/her home under an emergency protective order, DFPS cannot re-enter the residence. However, if DFPS alerts law enforcement that the proposed ward's home will be left vacant, law enforcement can then monitor the home.

*DADS' Review of Ward's Capacity*
Each year, DADS reviews all active guardianship cases to determine whether:

- the guardianship is still necessary and appropriate;
- the ward is being served in the least restrictive, most integrated setting possible; and
- DADS' Guardianship Services Program is the only program or entity available and appropriate to serve as guardian or a more suitable person is willing and able to serve as successor guardian.[48]

If DADS learns an individual is willing and able to serve as successor guardian, DADS must notify the court in which the guardianship is pending.[49] Also, in the event that a ward regains capacity long before the court's annual review, DADS' Guardianship Services Program staff may help the ward seek restoration and dismissal of the guardianship under the court's direction.[50]

*Number of Wards a Guardian May Serve*

As of November 2010, approximately 328 Texans were certified as professional guardians, collectively serving over 4,700 wards.[51] Some professional guardians have multiple wards assigned to them, making it difficult for a guardian to act in the best interest of each ward under these circumstances. A number of guardianship reform advocates believe Texas should limit the number of wards assigned to a professional guardian. Professional guardians must notify the Office of Court Administration's Guardianship Certification Board (GCB) annually of the total number of wards they serve, but there is no limit on the total number of guardianships a professional guardian can assume.[52] Instead, the GCB requires guardians to limit their caseload to a size that allows them to adequately provide care, supervise and protect each ward, visit monthly with each ward, and have regular contact with all service providers.[53] Because state law is silent about the number of wards a guardian may serve, it may be helpful to include in statute the GCB's requirement for guardians to limit their caseload to a size that allows them to appropriately serve the ward and act in the ward's best interest. This change would not place any new restrictions or burdens on professional guardians but would establish needed parameters in statute.

**Other Considerations**

*Individuals who may Request or Contest a Guardianship*

With few exceptions, anyone may commence a guardianship proceeding to restore the ward's capacity, modify the guardianship, or contest a guardianship proceeding or the appointment of a guardian.[54] In addition, a court may take up its own review of an individual's competency if the court has reason to believe the individual is incapacitated.[55] To prevent local abuse and protect wards from individuals with an interest adverse to the ward, state law should be amended to limit the individuals who may commence a guardianship proceeding to the proposed ward, DADS or an individual interested in the proposed ward's welfare. Individuals interested in the proposed ward's welfare may include a sibling, child, parent, spouse, court ordered conservator of the proposed ward, a person with whom the proposed ward has lived for the past six months, and even the ward. In addition, the court should determine the individual's legal right to initiate a lawsuit (termed "standing") before taking any action on a petition to commence a guardianship proceeding. If the court finds the individual lacks standing, the court should dismiss the petition and assess all costs and fees against the individual.

*Notice Requirements*

Courts are not required to provide family members or other interested parties with notice of all actions involving a guardianship and notice requirements vary depending on the court's action. For example, after an application for guardianship has been filed, the court must notify a number of individuals, including the proposed ward's adult children and siblings and anyone named as the proposed ward's next of kin in the guardianship application.[56] In comparison, "if necessity exists," the court is not required to provide notice when a guardian is removed or resigns and the court appoints a successor guardian.[57] To protect the ward and his/her assets, a court may choose not to give prior notice of a guardian's removal. However, providing no notice may lead to unintended consequences. For example, the court may remove a guardian without notice if the court finds the guardian abused or neglected the ward or embezzled or mismanaged the ward's property.[58] A guardian removed under these circumstances has 10 days to seek reinstatement.[59] However, because the court is not required to notify the removed guardian of his/her removal, it

is possible that the removed guardian would not learn of the court's action in time to seek reinstatement.

To ensure that family members and other parties interested in the ward's welfare receive timely notice of any actions involving the guardianship of a loved one, state law should be amended to require courts to provide these individuals with immediate notice of any changes in a guardianship, including the removal or resignation of a guardian and the appointment of a successor guardian. In addition, courts should notify individuals immediately upon their removal as the ward's guardian and give them 30 days to seek reinstatement. Finally, courts should appoint a successor guardian on a temporary basis[60] to allow family members, friends and other parties interested in the ward's welfare to serve as the ward's successor guardian, assuming these individuals are willing, able and qualified to serve in this capacity.

Some guardianship reform advocates suggest that courts hold a family meeting *before* removing a family guardian and to appoint other family members or friends as successor guardian instead of a professional guardian. State law currently requires courts to consider family members willing and able to serve as the ward's guardian before granting guardianship to a private guardianship contractor.[61] However, holding a family meeting before removing a guardian may not always be in the ward's best interest. For example, if a court finds the ward's health or safety is at imminent risk due to the guardian abusing or neglecting the ward, the court should be able to immediately remove the guardian rather than allow the ward to remain in a state of abuse or neglect pending the outcome of a family meeting.

*Ward's Rights During Guardianship*

Under Texas law, a ward "retains all legal and civil rights and powers except those designated by court order as legal disabilities by virtue of having been specifically granted to the guardian."[62] To limit the role of a guardian to the minimum necessary, give greater effect to an individual's estate planning and prevent local abuse, state law should be amended to clarify that probate courts cannot consider the following rights of the ward as "legal disabilities," thereby allowing the ward to retain these rights during a guardianship:

- right to retain and compensate an attorney;
- right to appeal or contest any action by the guardian ad litem;
- right to appeal or contest any action by or before the court;
- right to appeal or contest the fees or expenses ordered to be paid from the ward's estate;
- right to change a will; and
- right to associate with a particular person or persons.

*Volunteer Guardians*

Some guardianship reform advocates believe DADS does not utilize volunteers to their fullest potential. A number of professional guardianship programs have used volunteers as guardians for several years, authorizing them to sign documents and make decisions with staff consultation. Whenever possible, DADS should encourage the use of volunteers to assist with guardianships administered by DADS' Guardianship Services Program.

## Recommendations

1. **Direct the Department of Aging and Disability Services and the Department of Family and Protective Services to further streamline the guardianship process to prevent unnecessary duplication of efforts.**

2. **Upon the removal of a parent or family member as the ward's guardian, direct courts to immediately notify former guardians of their removal and give them 30 days to seek reinstatement.**

3. **Upon the removal of a parent or family member as the ward's guardian, make the court's appointment of a successor guardian temporary in order to allow other family members to step forward and serve as the ward's guardian.**

4. **Direct probate courts to provide family members notice of hearings to determine whether guardianship of a loved one is appropriate, or to determine changes in guardian or guardianship status.**

5. **Limit the individuals who may request or contest a guardianship to (1) the proposed ward, (2) the Department of Aging and Disability Services, or (3) an individual interested in the proposed ward's welfare.**

6. **Allow a ward to retain an attorney; appeal or contest any action by the guardian ad litem or the court, including fees or expenses ordered to be paid from the ward's estate; change a will; associate with particular person(s) and give effect to a previously executed durable power of attorney.**

7. **Direct Adult Protective Services to alert law enforcement after removing an individual pursuant to an emergency order authorizing protective services if the individual's home is left vacant in order to allow law enforcement to monitor the home.**

8. **Encourage the use of volunteers to assist with Department of Aging and Disability Services guardianships.**

---

[1] Texas Probate Code §602.
[2] *Id.* at §601(14)(B).
[3] Department of Aging and Disability Services Presentation to the Senate Committee on Health and Human Services (hereinafter termed "DADS Presentation"), May 12, 2010, slide 2. Available online at http://www.dads.state.tx.us/news_info/presentations/SHHS-guardianship-5-12-10.pdf (Last accessed July 27, 2010).
[4] Texas Probate Code §602.
[5] *Id.* at §601(11).
[6] *Id.* at §767(a). The Guardianship Certification Board's minimum standards for the provision of guardianship services also include a number of duties of the guardian of the person. See http://www.courts.state.tx.us/gcb/pdf/ms-011907amend.pdf (Last accessed November 9, 2010).

[7] *Id.* at §768. The Guardianship Certification Board's minimum standards for the provision of guardianship services also include a number of duties of the guardian of the estate. See http://www.courts.state.tx.us/gcb/pdf/ms-011907amend.pdf (Last accessed November 9, 2010).
[8] DADS Presentation, slide 5.
[9] DADS also provides guardianship services to (1) incapacitated individuals aging out of Child Protective Services conservatorship and (2) individuals a court with probate authority refers directly to DADS' guardianship program (often because the individual lives over 100 miles from the court and no other individual or entity is available to serve as guardian).
[10] Memorandum of Understanding Concerning Delivery of Guardianship Services, effective December 1, 2004. Available online at http://www.dfps.state.tx.us/handbooks/APS/APS_memos/DFPS_DADS_MOU.pdf (Last accessed July 27, 2010). In September 1993, the state Guardianship Services Program was established as part of the Adult Protective Services (APS) program to serve children aging out of foster care. In September 1995, it was expanded to include APS clients. In 2005, the 79th Legislature passed Senate Bill 6 (Nelson/Janek et al.), which transferred the state's Guardianship Services Program from DFPS to DADS. See DFPS Presentation to Senate Health and Human Services Committee, May 12, 2010, slide 4 (hereinafter referred to as "DFPS Presentation"). Available online at http://www.dfps.state.tx.us/About/Legislative_Presentations/APS/default.asp (Last accessed November 8, 2010).
[11] Information provided by the Office of Court Administration via email dated November 9, 2010.
[12] In addition to neglect perpetrated by a caregiver, family member or other individual, neglect may also be perpetrated by the individual (termed "self neglect"). Examples of self neglect include an individual with dementia who wanders, placing him/herself in danger of physical harm or an individual who fails to obtain necessary treatment for a serious medical or mental health condition.
[13] Human Resources Code §48.209(a)(2), (b).
[14] Under Texas law, DADS must limit its guardianship services to individuals who have private assets or government benefits to fund their needs. DADS Guardianship Services Program cannot accept a proposed ward who lacks the funds needed to pay for his/her care (e.g., Medicaid, personal accounts and property, retirement funds). In addition, DFPS cannot refer undocumented individuals to DADS because they will not be eligible for government benefits necessary for their care due to their immigration status.
[15] Information provided by DFPS via email dated July 29, 2010.
[16] *Id.*
[17] DFPS Presentation, slide 7.
[18] *Id.* According to DFPS, assessments must be sought when a client is refusing services or legal action has been taken. Assessments are not required for all investigations. However, many workers will request an assessment even when it is not required.
[19] DFPS funds protective services through the Emergency Client Services Fund (both General Revenue and Temporary Assistance for Needy Families funds).
[20] Table prepared by DADS and sent via email dated November 12, 2010.
[21] Memorandum of Understanding Between DFPS and DADS Concerning Guardianship Services, effective October 26, 2009, page 9.
[22] *Id.* at page 12.
[23] Information provided by DADS via email dated November 10, 2010.
[24] *Id.*
[25] Human Resources Code §161.103.
[26] *Id.* at §161.101(b).
[27] If DADS becomes aware of a guardianship program, private professional guardian or other individual willing and able to provide guardianship services instead of DADS, DADS must refer the individual to that person or program for guardianship services. *See* Human Resources Code §161.102(a).
[28] Memorandum of Understanding Between DFPS and DADS Concerning Guardianship Services, effective October 26, 2009, pp. 1–2. DADS may obtain a Certificate of Medical Examination for an alternate guardian or assist an alternate guardian in obtaining one.
[29] Human Resources Code §161.101(c).
[30] HB 3112 (81R; Hartnett/Nelson).
[31] *Id.* According to DADS, the average number of days from receipt of an Adult Protective Services (APS) referral to the filing date in fiscal year 2010 was 35 days. DADS did not request any extensions of the 70 day disposition requirement in fiscal year 2010. Information provided by DADS via email dated November 10, 2010.

[32] DADS Presentation, slide 11.
[33] Information provided by DADS via email dated June 14, 2010.
[34] *Id.*
[35] Memorandum of Understanding Between DFPS and DADS Concerning Guardianship Services, effective October 26, 2009, page 12.
[36] Information provided by DADS via email dated June 10, 2010.
[37] *Id.*
[38] DADS Presentation, slide 13.
[39] Texas Probate Code §672(a).
[40] *Id.* at §694A(a)(1), (3).
[41] *Id.* at §694A(e).
[42] *Id.* at §743(g).
[43] *Id.* at §743(a).
[44] *Id.* at §743(b).
[45] *Id.* at §741(a)–(b).
[46] *Id.* at §776(b).
[47] *Id.* at §776(b).
[48] Human Resources Code §161.108. *See also* DADS Presentation, slide 14.
[49] *Id.*
[50] DADS Presentation, slide 14.
[51] Information provided by the Office of Court Administration Guardianship Certification Board via email dated November 9, 2010. The number of certified guardians as of November 8, 2010 is 280 certified and 48 provisionally certified, for a total of 328. As of December 2009, private professional guardians served 310 wards, guardianship programs served 3,219 wards, and DADS' Guardianship Services Program served 1,181 wards, for a total of 4,710 wards. *See also* "Abuse cases put focus on court-appointed guardians," Houston Chronicle, October 28, 2010.
[52] Information provided by the Guardianship Certification Board via email dated June 29, 2010.
[53] Minimum Standards for Guardianship Services, Guardianship Certification Board, p. 12. Available online at http://www.courts.state.tx.us/gcb/pdf/ms-011907amend.pdf (Last accessed November 9, 2010).
[54] Texas Probate Code §642(a).
[55] *Id.* at §683(a).
[56] *Id.* at §633(d).
[57] *Id.* at §760(b); §761(a), (f).
[58] *Id.* at §761(a)(6)–(7).
[59] *Id.* at §762(a).
[60] According to Texas Probate Code §694(a), unless otherwise discharged as provided by law, a guardian remains in office until the estate is closed.
[61] Texas Probate Code §676–677.
[62] *Id.* at §675.

Interim Charge #7: *Examine how the state could enact policies to improve the overall health of Texans, focusing on programs that compliment individually-based prevention with community-based prevention to reduce obesity rates by increasing physical activity, improving nutrition, and improving self-management of chronic diseases such as diabetes. Examine obesity-related health disparities between different ethnic groups and ways to narrow these gaps. Consider the fiscal and health impact of second-hand smoke on businesses and service sector employees. Study state-level initiatives to incorporate these individual and community-based prevention strategies, including initiatives pursued in other states.*

# Section I: Background

Obesity and tobacco use are the two greatest health-related challenges facing Texas, according to Dr. David Lakey, Commissioner of the Texas Department of State Health Services (DSHS).[1] State investments in prevention and public health should reflect these priorities, and research shows that prevention pays off: every $1 invested per person to promote healthy lifestyles and prevent chronic diseases leads to a $5.60 reduction in health care costs.[2] The majority of state programs aimed at preventing or reducing levels of obesity have been focused primarily on school-based efforts and on individual-level interventions that emphasize personal responsibility for healthy lifestyles. These approaches are important and have produced significant results, particularly in children. However, as our obesity rates and the associated costs to Texas taxpayers and businesses continue to climb, community-level interventions that compliment these programs have begun to receive more interest from state and local advocates and researchers in the field of obesity prevention. State agencies and other entities are increasingly incorporating these community-based strategies into programs that aim to prevent and reduce obesity.

# Section II: Analysis

## Impact of Obesity

Texas ranks 13th nationwide in the rate of obese and overweight people, with 66% of Texas adults considered either overweight or obese. The state ranks 9th in both prevalence of diabetes, a chronic disease frequently associated with obesity, and in the level of physical inactivity.[3] In addition to increasing the incidence of chronic diseases and shortening the length and quality of life, obesity is also extremely costly. A report released by the Texas Comptroller of Public Accounts in 2007 estimated that the annual cost of obesity to businesses in 2005 was $3.3 billion dollars. $1.4 billion of this was in direct health care costs, $1.2 billion in lost productivity, $591 million in absenteeism, and $116 million in disability. It is projected that if Texas' obesity rates continue on their current path, costs to Texas businesses in 2025 will total $15.8 billion annually.[4] Obesity even has national security consequences, as recent data shows that 27% of 17-24 year-olds are too overweight to serve in the military. This has led a group of over 100 retired military generals and admirals to call on Congress to reauthorize the Child Nutrition Act to strengthen nutrition policies in public schools.[5]

## Strategies to Prevent and Reduce Obesity

Historically, programs in Texas aimed at preventing or reducing obesity have been focused on increasing personal responsibility among individuals who are obese or at risk of becoming obese,

and at imparting healthy lifestyles on children through school-based programs. School-based interventions continue to represent the most significant impact state lawmakers can make on the obesity epidemic, and the importance of personal responsibility for one's health cannot be overstated as the first step in addressing obesity. However, solely focusing on personal responsibility does not adequately address the scope of Texas' obesity problem, as it is difficult for individuals to make responsible choices if they live in environments that undermine healthy decisions and promote unhealthy ones. In recent years, many interventions in Texas have coupled personal responsibility and education with efforts to encourage communities to foster environments where individuals can easily make the choices that will improve and maintain their health. These programs have generally focused on improving the built environment to be more conducive to physical activity, expanding access to healthy foods, and sharing best practices in these two areas. Policymakers should continue to balance these approaches -- personal responsibility and community-based solutions -- in an effort to create community-wide cultures of health across Texas and to make it easier for individuals to make healthy choices.

**Improving the Built Environment**

Advocates and researchers have increasingly emphasized the importance of improving the built environment, meaning ensuring that neighborhoods are designed to promote incorporating regular physical activity into everyday life. Many neighborhoods have been designed in a way that does not support physical activity, or have devolved into places that discourage physical activity. While parents may want to encourage their children to play outside and understand the importance of physical activity, many live in areas with dilapidated sidewalks that are dangerously close to heavy traffic, preventing children from walking or riding bikes to school. Similarly, many neighborhoods lack access to parks and playgrounds.[6]

*Safe Routes to Schools*

Since 2005, the Texas Department of Transportation has administered the federally-funded Safe Routes to Schools program, which uses a variety of education, engineering, and enforcement strategies to make it safer and more desirable for children to walk and bike to school. Programs are administered through grants to local governments across the state. Since 2005, Texas has received $44,751,640 to fund these projects.[7] According to participants, Safe Routes to Schools programs have been extremely successful in increasing the number of children walking and biking to school and improving the conditions of walking and biking paths. Texas A&M University funds the Texas Childhood Obesity Prevention Policy Evaluation (T-COPPE) project to evaluate the impact of Safe Routes to Schools programs in Texas. This extensive evaluation project is funded from 2009-2013. So far, T-COPPE has created a measurement tool to evaluate the program and has established baseline measures. Over the next several years, T-COPPE will monitor changes in the baseline measures and monitor qualitative assessments. A final evaluation of Safe Routes to Schools is expected in 2013.[8]

*Community Based Grants*

DSHS was appropriated $4.7 million in General Revenue during the 81st legislative session to make competitive grants to local health departments, universities, hospitals, and non-profit organizations to implement evidence-based strategies to reduce obesity. Of the eleven grants awarded, five are at least partially focused on improving the built environment. These projects range from extending walking trails, building well-lit sidewalks in neighborhoods, and connecting a downtown urban area with a residential park through a trail system. DSHS has

included an Exceptional Item in its Legislative Appropriations Request (LAR) of $4 million to expand these grants to other communities. As lawmakers craft the next state budget, they should carefully analyze the performance and impact of existing grants to ensure that scarce funding targets the programs that are having the greatest impact on the greatest number of people.

*Joint Use Agreements*

In many communities, tracks and other recreational facilities at neighborhood schools offer a convenient, no-cost way to obtain physical activity and interact with other community members. However, schools often restrict access to these facilities after hours to protect the property as well as to avoid any liability for injuries that may occur on the property. Some communities have overcome these challenges by entering into Joint Use Agreements (JUAs). JUAs are formal agreements between two separate government entities -- in this case a school and a city or county-- establishing terms and conditions for the shared use of facilities or property. Ideally, a public use agreement would allow citizens within a community to utilize indoor and outdoor recreational and athletic facilities at a school during non-school hours to promote physical activity within that community.[9] Schools and local governments in Texas are currently able to enter into these agreements, but some are unaware of the opportunity or how to overcome the security concerns. These details must be determined before a public use agreement can be implemented successfully. The state should work to connect schools and communities that wish to enter into such contracts and connect them with free legal assistance to create acceptable contracts addressing all issues involved in such an agreement.

**Improving Access to Healthy Foods**

Perhaps the most significant barrier obese and overweight people face in making responsible healthy choices is a lack of access to healthy foods. In many communities, it is extremely difficult to obtain fresh, healthy foods because neighborhoods are packed with fast food restaurants and convenience stores selling cheap, calorie-dense food, rather than grocery stores and other retailers that carry healthier alternatives.[10]

The 81st Legislature passed SB 343 (Nelson) creating the Healthy Food Retail Advisory Committee to examine the lack of access to fresh healthy food retailers, including grocery stores, in underserved areas of the state.[11] The Advisory Committee is expected to issue a report prior to the 82nd legislative session containing recommendations and a financing plan to expand healthy food grocers and other retailers in these parts of the state.

Governments in other states are implementing plans to bring fresh produce retailers to underserved areas of their communities. In Pennsylvania, for example, the Fresh Food Financing Initiative (FFFI) was created in 2004 as a public-private partnership with an initial $10 million state investment. So far, the state has allocated a total of $30 million in General Revenue and the Reinvestment Fund (TRF), an investment firm that works exclusively on community revitalization projects, has leveraged this into an additional $120.6 million in private funds. These funds have been used as a pool for grocery stores and supermarkets to use for capital to locate in underserved neighborhoods where access to fresh, healthy foods is a serious problem. To date, 93 of 206 funding applications from retailers have been approved, resulting in $73.2 million in loans to retailers, $12.1 million in grants, and the estimated creation of over 5,000 jobs.[12]

*Community-Based Grants*

Of the $4.7 million in DSHS community-based grants that were funded during the last legislative session, four of the eleven grants at least partially focus on improving access to healthy, fresh foods. For example, the City of San Antonio Metropolitan Health District is working to establish nutrition standards for foods and beverages served to children participating in after-school programs and camps and is working with local restaurants to encourage them to offer healthier options. Additionally, the City of Austin Health and Human Services Department is convening local stakeholders to create an implementation plan to promote the availability of affordable healthy foods and beverages.[13]

*Farmers' Markets*

Farmers' markets offer a way to connect local farmers with citizens and promote fresh, healthy food choices. During the 81st Legislative session, lawmakers attempted to expand access to farmers' markets for low-income individuals who receive benefits through nutrition assistance programs such as Women, Infants, and Children (WIC) or the Supplemental Nutrition Assistance Program (SNAP), formally known as the food stamp program. SB 344 (Nelson) would have required a study to determine the costs, benefits, and feasibility of incorporating WIC and SNAP benefits at farmer's markets.[14] SB 1088 (Shapleigh) would have required acceptance of SNAP benefits at all farmer's market locations across Texas.[15] Although neither of these bills passed, the Texas Department of Agriculture (TDA) and the Health and Human Services Commission (HHSC) are launching a federally-funded pilot program at 25 farmers' market locations across the state to provide vendors with hand-held scanners to process SNAP benefits contained on Lone Star cards. Depending on the results of this pilot, the state may find it cost-effective to expand the provision of these scanners to farmers' market vendors throughout the state.

Advocates have also pointed to farmers' markets as venues where those unfamiliar with how to prepare certain fruits and vegetables could learn cooking techniques through demonstrations. However, current law prevents vendors at farmer’s markets from performing demonstrations. This is due to a variety of issues including the lack of an improved water source and food handling safety. DSHS has facilitated a state advisory group that is currently in the process of proposing possible changes to these rules that will allow for demonstrations at farmer's markets.

*Community Gardens*

Another potential low-cost source of healthy foods is community gardens. These are parcels of land, typically in urban neighborhoods, that are divided into garden plots and assigned to individuals, families or groups wishing to garden. Community gardens provide recreation and fresh produce for residents. Recently, some city governments have investigated the possibility of utilizing unleased or underutilized state property for the cultivation of community gardens. Salt Lake County in Utah has begun implementing an urban farming plan to transform more than 150 acres of land into community gardens, commercial farms, and biofuel plots. The land intended for these uses is expected to eventually be used for recreation areas and parks, but city officials do not anticipate those developments to occur for several years. In the meantime, they have made the land available to community groups and small farmers through discounted leases.

The City of Austin is also investigating how to expand community gardens on city-owned land. The Austin City Council adopted a resolution in November 2009 directing the City Manager to streamline the process of establishing community gardens, make changes to city code necessary to facilitate the development of community gardens, identify and map public lands that would be appropriate for urban agriculture and community gardens, and gauge public interest in these endeavors.[16] Thus far, the city has identified the necessary changes to city code and has outlined a licensing process and other necessary steps a community group or individual would need to take in order to establish a community garden on city land. The city has encountered barriers to fully implementing a plan to utilize city land, and is considering issues ranging from water fees to zoning regulations.[17]

Texas should take similar steps to utilize unleased state land for the cultivation of community gardens. As in the experience of Austin city officials, there may be significant barriers to accomplishing this. Land available for these uses may not be suitable for use as community gardens, either because it is not arable, or because it is too remote to draw significant interest. These issues and others represent challenges to utilizing state property for community gardens but are not necessarily insurmountable. The General Land Office (GLO) should identify state land that could potentially be used for community gardens, create a plan that identifies the barriers the state faces in implementing such a plan, and advise the Legislature on how these barriers can be overcome.

**Improving School-Based Programs**

The most profound impact that lawmakers have in addressing the obesity epidemic in Texas is through school-based prevention and intervention. It is essential to continue this progress by supporting and strengthening these efforts.

*Enhancing Existing School-Based Programs*

Although schools have been required over the past several years to implement more stringent physical education, physical activity, and nutrition requirements due to statutory changes or agency changes made by rule, these laws and regulations are difficult to enforce and their implementation is challenging to track. Communities and schools in Texas are given significant flexibility to enforce these laws and maintain local control. The Texas Education Association (TEA) does not have the ability to monitor and enforce laws that apply to the thousands of schools and millions of students across the state. To allow schools and teachers maximum flexibility in meeting these requirements and to ensure that state statute is being followed, reporting requirements should be expanded to track school district and individual campus progress in implementing provisions that are required in state law or due to agency rule.

There are currently some reporting requirements in place. The 81st Legislature passed SB 892 (Nelson), requiring that elementary, middle and junior high school campuses include goals and objectives for their Coordinated School Health (CSH) programs in their annual Campus Improvement Plans (CIPs) that are submitted to the Legislature.[18] To expand on this requirement and increase accountability, these CIPs should also include goals and objectives to ensure compliance with the Texas Public School Nutrition Policy (TPSNP), which specifies nutrition standards for food served on school campuses. School Health Advisory Councils (SHACs) are also required to submit an annual report to the school board. SHACs, committees

that advise the school board on how to ensure student health in their districts, are made up primarily of parents and other community members. Each SHAC must issue an annual report to the school board including recommendations related to the district's health education curriculum and instruction. These reports should be expanded to include a summary of each campus's compliance with requirements related to daily minimum physical activity and implementation of CSH programs.

In addition to increasing these reporting requirements, Texas should work to ensure that every Texas child participates in at least 30 minutes of physical activity each day. Currently, children in grades pre-Kindergarten through 5th grade must participate in at least 30 minutes of moderate to vigorous physical activity each day. Middle school children must participate in 30 minutes of moderate to vigorous daily physical activity for four out of six semesters.[19] Until the 2009-2010 school year, high school students were required to complete 1.5 semesters of physical education (PE) and a half semester of health education in order to graduate. The 81st Legislature passed HB 3 (Eissler), reducing the PE requirement to just one credit and eliminating the health education requirement.[20] Local school boards have the option to enforce more stringent requirements than the minimum required in state statute, and many have chosen to maintain the more stringent requirements in place prior to the passage of HB 3. Others, however, have adopted the new minimum standards.

At a time when obesity rates in older children are especially high and continue to rise, PE requirements in high school should be reinstated to one and a half credits, and middle school students should be required to participate in daily physical activity all six semesters. National guidelines suggest at least 60 minutes of physical activity per day for children to maintain a healthy lifestyle. Since children spend so much of their time at school, it is logical that at a minimum, half of this requirement be attained during the school day. Additionally, nationally-recognized research has established the link between academic achievement and physical health. Therefore, increasing physical activity requirements in schools serve to enhance academic achievement, not take away from it.[21]

*School Recognition*

Although many schools have excelled in implementing the various statutory changes made over recent years to strengthen student health, they have too often gone unrecognized for their efforts. Recently, non-profit organizations and corporations have recognized this fact and created programs that will reward schools for their achievements in student health. The Cooper Institute and the United Way of Metropolitan Dallas have created the Healthy Zone School Recognition Program, which offers monetary rewards to schools who have shown improvement in their Fitnessgram fitness assessment scores.[22] These assessments are required in Texas public schools on an annual basis for children in grades 3-12 to determine if a child falls into a 'Healthy Fitness Zone' in six areas including body composition, endurance, and flexibility.[23] Another program recently announced by the H-E-B Corporation called the Fit Campus Award will award $10,000 to 10 schools who have made outstanding achievements in creating healthy lifestyles among students and staff, achieved parental and community involvement in school health, and raised awareness of the importance of physical activity and nutrition. The funding must be used to expand health and fitness programs.[24]

The Commissioner of TEA may currently award a campus distinction designation for schools that have outstanding achievement in PE programs.[25] However, this distinction does not recognize a school's efforts in health education, Coordinated School Health implementation, Fitnessgram assessments, and other student health initiatives. To expand on the current capabilities of the agency, recognize schools that are showing achievements in several areas of school health, and capitalize on the interest these private and non-profit groups have shown, the Commissioner of the Texas Education Agency (TEA) should create a tiered, application-based healthy school recognition program that awards schools based on achievement on Fitnessgram assessments, implementation of Coordinated School Health programs as required by law, compliance with required minimum levels of daily physical activity, and the activities of SHACs. The Commissioner should form partnerships with non-profit and for-profit entities that have already developed similar programs to supply schools with externally-funded monetary and in-kind rewards for use on expanding student health at their campuses.

*Enhancing Parental Involvement*

SHACs offer parents and other members of the community an opportunity to have a voice in what students learn about health, nutrition, and physical activity during the school day. Parental involvement is crucial to ensure that the healthy habits a child learns in school are carried home after the school day ends and to extend healthy lifestyle lessons from a child to the entire family. Another opportunity for parents to be involved in the health of their children is to learn how their child is performing on annual fitness assessments and how those scores relate to their academic performance.

TEA is currently required to analyze Fitnessgram assessment data and identify correlations with academic achievement levels, attendance levels, obesity, disciplinary problems, and school meal programs. Since schools are prohibited from submitting individual student data to TEA, it is impossible for the agency to generate accurate correlations on a per-child basis. In other words, although TEA may be able to state that a school has low scores on fitness assessments and high rates of obesity, they cannot state that children with low fitness scores also have higher obesity rates. Requiring schools to submit individual scores in a way that removes any information that may be used to identify a student would allow for better correlation of results, while still protecting the student's privacy. Additionally, enabling parents to view their child's results and correlations through a secured, password-protected source would give them a better picture of their child's health and fitness, and how that relates to their academic achievement.

**Sharing Best Practices**

Many communities across Texas are already implementing successful programs to prevent and reduce obesity by improving the built environment and increasing access to healthy foods. These programs range from encouraging and facilitating breastfeeding among new mothers, re-building dilapidated parks by utilizing volunteers from the community, and partnering with local restaurants to introduce healthier items to their menus. However, it is difficult for communities scattered across the state to share their experiences and the best practices they have developed in implementing these programs.

DSHS administers a program called "Bringing Healthy Back", a grassroots campaign aimed at reducing obesity rates by improving nutrition and physical activity rates in communities.

Currently, Bringing Healthy Back is in the process of implementing the Growing Community video series, which will serve as a communication and education tool for grass-roots programs across the state. DSHS, utilizing its existing base of local health departments and non-profits, as well as its 11 regional health offices, is recruiting communities that have implemented successful obesity prevention and reduction programs to host short, 5-8 minute screenings showcasing their programs. DSHS is providing technical assistance and compiling these screenings into six DVDs based on the six evidence-based target areas recommended by the Centers for Disease Control and Prevention (CDC) as having the greatest impact on obesity reduction: increasing physical activity, decreasing TV viewing time, increasing consumption of fresh produce, decreasing consumption of high energy-dense foods, decreasing consumption of sugar-sweetened beverages, and increasing breastfeeding. DSHS will distribute these DVDs to community-based partners throughout the state to inform their efforts to address obesity in their communities.

**Child Care/Early Childhood Settings**

An area of increasing attention in recent years has been improving health in early childhood settings such as pre-schools and day care centers. Almost one in every five 4-year-olds in this country are obese.[26] The nutrition and physical activity habits learned in the earliest years of life, whether good or bad, carry on into adolescence and adulthood. In fact, 70% of overweight children will become overweight adults.[27]

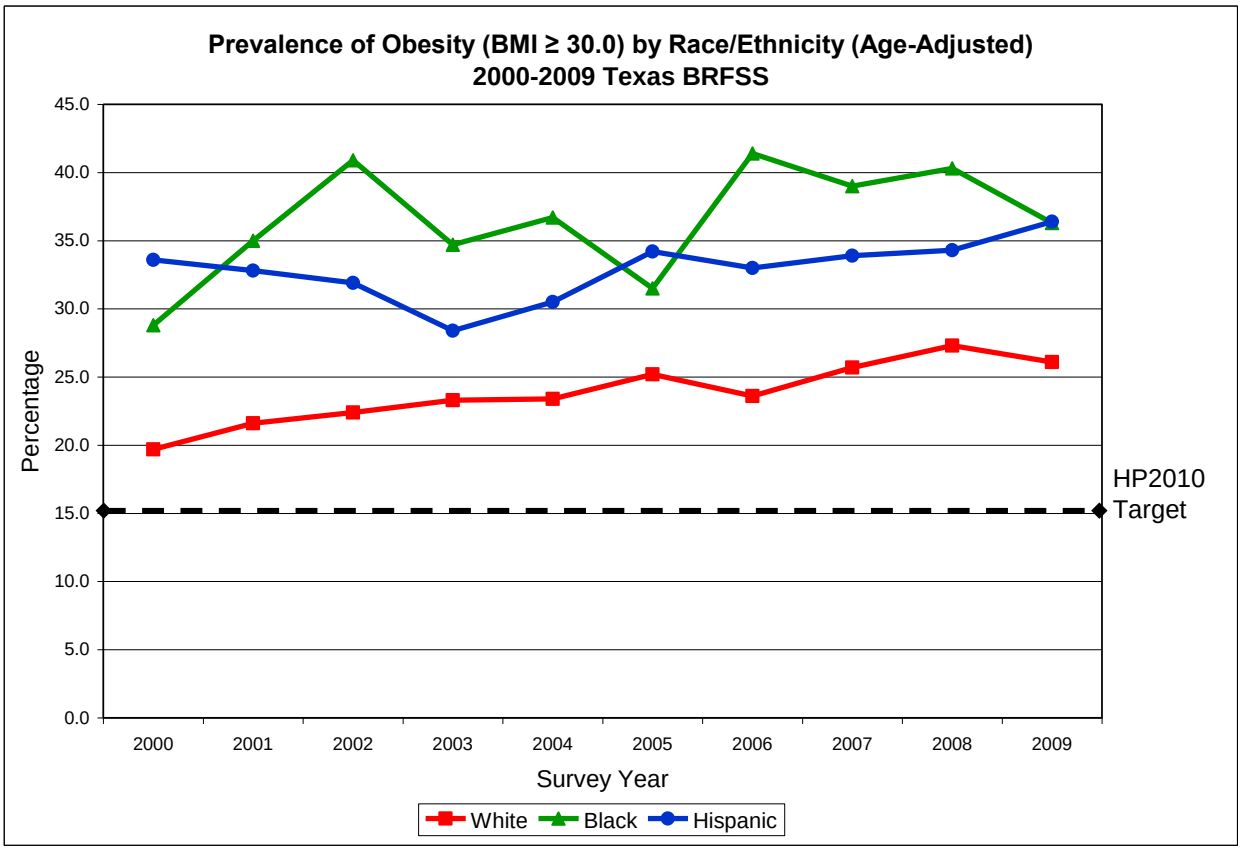
The 81st Legislature passed SB 282 (Nelson), creating a grant program for early childhood and after school programs to invest in curriculum and other materials to expand nutrition education. The first round of grants has been awarded, with 44 recipients receiving a total of approximately $400,000 to expand nutrition education. The next round of grants will be awarded in early spring 2011.[28] SB 395 (Lucio), also passed by the 81st Legislature, created the Early Childhood Health and Nutrition Interagency Council, a group charged with assessing the health of Texas children under the age of six and the existence of physical activity and nutrition standards in early childhood settings such as day cares. The council is also charged with identifying barriers to improving nutrition and physical activity standards in early childhood settings and creating a six-year plan to: increase fruit and vegetable consumption and daily structured and unstructured physical activity among children under the age of six; increase breastfeeding in infants and young children; and educate and increase the awareness of parents and caretakers regarding the need for proper nutrition.[29]

Physical activity and nutrition standards in child care centers are generally established through rule by the Department of Family and Protective Services (DFPS). As of December 1, 2010, new agency rules require licensed child care facilities to limit screen time (including television, videos, computers, or video games) to two hours of age-appropriate programming for children over age two and prohibit screen time for children under two; serve water at every snack, mealtime, and after active play; and not serve sugar-sweetened beverages.[30] Agency leaders and lawmakers should continue to work with child care providers and the Early Childhood Health and Nutrition Interagency Council to implement physical activity and nutrition standards that support a healthy lifestyle for young children.

## Health Disparities

Some populations, particularly those that are low-income or predominantly minority, are even further behind in the battle against obesity. For example, areas with concentrated Hispanic populations have the highest obesity and overweight prevalence in the state, and Hispanics die from diabetes and related complications at double the rate of white Texans.[31] According to the CDC Behavioral Risk Factor Surveillance System (BRFSS), obesity rates for both Hispanics and African Americans in Texas hovered at about 37% in 2009, compared to the corresponding rate for white Texans of 26% (see Figure 1).

### Figure 1: Obesity rates by race/ethnicity, CDC BRFSS 2009[32]




Health disparities are caused by a variety of factors, most prominently income differences, lack of access to health care, and unhealthy environments. Improving access to healthy foods and physical activity also serve to narrow the gap in health outcomes between different ethnic and racial groups. In 2001, HB 757 (Coleman) created the Health Disparities Task Force to study the extent of health disparities and strategies to reduce them. In 2003, HB 2292 (Wolgemuth) created the Office for the Elimination of Health Disparities (OEHD) housed at HHSC to provide leadership and support for the Task Force. The OEHD currently has several initiatives underway to address health disparities:

- *Health Disparities Index Project (HDI):* Created a baseline for the state's efforts to eliminate racial and ethnic health disparities and monitors progress towards eliminating health disparities.
- *Dialogue Sessions:* Convenes communities with high percentages of health disparities and collect suggestions, ideas, and experiences from community partners on how to improve the availability and delivery of care in disadvantaged communities.
- *Regional Health Disparities Projects:* OEHD coordinated with DSHS Regional Office staff across the state to implement projects ranging from coalition building to outreach and education initiatives.
- *Community Information Network:* OEHD maintains a database with more than 25,000 community-based organizations, researchers, and professionals and sends these partners information about meetings, emerging issues in health disparities, and funding opportunities for community-level projects.
- *Resources Clearinghouse:* Collection of research, informational brochures, and training materials available to OEHD and HHSC staff and community partners.

Moving forward, focusing attention on initiatives to improve the built environment and expanding access to healthy foods will have a positive impact on the goal of eliminating health disparities.

## Economic and Health Impacts of Secondhand Smoke

Although tobacco rates have significantly declined in Texas over the past 15 years, about 18% of adults in Texas still smoke cigarettes, and many use tobacco in other forms.[33] Secondhand smoke affects those in the vicinity of smokers, even if they do not smoke themselves. In fact, it causes premature death in children and adults who do not smoke, and children exposed to secondhand smoke are at an increased risk for a variety of health problems, including acute respiratory infections, severe asthma, and Sudden Infant Death Syndrome (SIDS).[34] Nonsmokers who are exposed to secondhand smoke have a 20-30% increased chance of developing lung cancer.[35]

The workplace is a major source of secondhand smoke exposure for adults, especially employees in the service industry who work in bars and restaurants where smoking is often permitted. According to the U.S. Surgeon General, "There is no risk-free level of secondhand smoke exposure, with even brief exposure adversely affecting the cardiovascular and respiratory system. Only smoke-free environments effectively protect nonsmokers from secondhand smoke exposure in indoor spaces."[36] Separating smokers from non-smokers, cleaning the air, and ventilating the building cannot prevent exposure if people still smoke inside the building.[37]

The costs of secondhand smoke is borne primarily through negative health impacts for employees and increased costs for both employees and employers. Employee illness due to secondhand smoke increases absenteeism, health insurance and life insurance costs, and workers compensation payments.[38] Additionally, smoking in workplaces contributes to accidental fires, property damage, and increases cleaning and maintenance costs. The U.S. Environmental Protection Agency (EPA) has predicted that restaurants that do not allow smoking can save about $190 per 1,000 square feet each year in lower cleaning and maintenance costs.[39]

## Section III: Conclusion

Obesity is one of the most profound health issues facing our state, both in terms of the impact on people's quality of life, as well as its financial impact on state budgets, taxpayers, and businesses. Fortunately, obesity is also almost entirely preventable. The keys to preventing and reducing the impact of obesity are good nutrition and physical activity. Although it is important to emphasize personal responsibility for one's health and urge people to make healthy choices, the healthy choice is often a very hard one to make. Environmental barriers such as a lack of safe outdoor spaces for exercise and a shortage of fresh food retailers are magnified by the readily available supply of cheap, convenient, calorie-dense fast food and pre-packaged foods. In moving forward to address the obesity epidemic, lawmakers in Texas should continue to promote efforts that encourage personal responsibility and ensure that students are eating healthy foods and being physical active throughout the school day. These efforts should be complimented by efforts to encourage communities to become places that make healthy choices easier choices for citizens to make. As minority groups are disproportionately overweight and obese in Texas, the solutions policymakers consider in attempting to reverse our obesity trends should also be crafted to reduce or eliminate these health disparities.

## Section IV: Recommendations

1. **Utilize unleased state property to cultivate community gardens.**

2. **Increase reporting requirements for schools and SHACs on compliance with requirements related to Coordinated School Health, nutrition, and physical activity.**

3. **Require daily physical activity for all public school children.**

4. **Create a Healthy School recognition program for campuses that excel in comprehensive school health.**

5. **Require schools to report de-identified individual Fitnessgram results to the Texas Education Agency (TEA) to facilitate more accurate correlations.**

---

[1] Lakey, Dr. David, Texas Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, (Austin, TX, September 8, 2010).
[2] Trust for America's Health, "Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities," 2008.
[3] Trust for America's Health, "F as in Fat: How Obesity Threatens America's Future," June 29, 2010, page 10.
[4] Texas Comptroller of Public Accounts, "Counting Costs and Calories: Measuring the Cost of Obesity to Texas Employers," Marc 2007.
[5] Mission: Readiness, "Too Fat to Fight: Retired Military Leaders Want Junk Food Out of America's Schools," September 21, 2010.
[6] Trust for America's Health, *Supra* note 3 at p. 77.

[7] National Center for Safe Routes to Schools: Federal Funding. Available: www.saferoutesinfo.org/legislation_funding/state_Apportionment.cfm. Accessed: November 11, 2010.
[8]Texas A&M University Institute for Obesity Research and Program Evaluation, Texas Childhood Obesity Prevention Policy Evaluation (T-COPPE). Available: www.orin.tamu.edu/research/t_coppe/index.php. Accessed: November 11, 2010.
[9] National Policy and Legal Analysis Network to Prevent Childhood Obesity, Model Joint Use Agreement, Available at: http://www.nplanonline.org/childhood-obesity/products/nplan-joint-use-agreements. Accessed: November 9, 2010.
[10] Trust for America's Health, *Supra* note 3 at p.77.
[11] Senate Bill 343, 81st Regular Session, 2009 (Nelson).
[12] The Reinvestment Fund, Philadelphia, "Pennsylvania Fresh Food Financing Initiative," Available: http://www.trfund.com/resource/downloads/Fresh_Food_Financing_Initiative_Comprehensive.pdf. Accessed: November 9, 2010.
[13] Dauster, Nick, Department of State Health Services. "Obesity Grants," Email to the author, September 15, 2010.
[14] Senate Bill 344, 81Regular Session, 2009 (Nelson).
[15] Senate Bill 1088, 81st Regular Session, 2009 (Shapleigh).
[16] Austin City Council, Resolution No. 2009119-065, Adopted November 19, 2009.
[17] Austin Parks and Recreation, Power Point Presentation before the Austin City Council, "Austin Sustainable Urban Agriculture: Proposed Ordinances in Support of Resolution #20091119-065," August 23, 2010.
[18] Senate Bill 892, 81st Regular Session, 2009 (Nelson).
[19] Texas Education Code, Sec. 28.002 (l).
[20] House Bill 3, 81st Regular Session, 2009 (Eissler).
[21] Centers for Disease Control and Prevention Division of Adolescent and School Health, "The Association Between School-Based Physical Activity, Including Physical Education, and Academic Performance," April 2010.
[22] Miller, Robert, Dallas Morning News, "United Way, Cooper Institute to Target Childhood Obesity," September 23, 2010.
[23] Fitnessgram Program Overview for Teachers, Available: http://www.fitnessgram.net/programoverview/teachers/. Accessed: November 12, 2010.
[24] HEB Fit Campus Award Application, Available: http://www.heb.com/sectionpage/about-us/community/excellence-in-education/26501118. Accessed: October 29, 2010.
[25] Texas Education Code, Sec. 39.203 (c)(3).
[26] Park, Madison, CNN Health, "It's Not Baby Fat: Among 4-year-olds, Nearly 1 in 5 is Obese," April 7, 2009.
[27] U.S. Department of Health and Human Services, Office of the Surgeon General, "The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity," January 2009. Available: http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_adolescents.htm. Accessed: November 12, 2010.
[28] Senate Bill 282, 81st Regular Session, 2009 (Nelson). Senate Bill 282 also awarded public schools for best practices in nutrition education and practice.
[29] Senate Bill 395, 81st Regular Session, 2009 (Lucio).
[30] Olse, Katie, Texas Department of Family and Protective Services. "DFPS Update on CCL Day Care Standards," Email to the author, September 21, 2010.
[31] Texas Health Disparities Task Force, "2008 biennial Report to the Texas Legislature," p. A-1.
[32] CDC National Center for Chronic Disease Prevention & Health Promotion, Behavioral Risk Factor Surveillance Survey. Available: http://apps.nccd.cdc.gov/brfss/display.asp?cat=OB&yr=2009&qkey=4409&state=TX. Accessed: November 10, 2009.
[33] Campaign for Tobacco-Free Kids, "The Toll of Tobacco in Texas," Available: http://www.tobaccofreekids.org/reports/settlements/toll.php?StateID=TX. Accessed: October 29, 2010.
[34] U.S. Department of Health and Human Services, "Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General," 2006, p. 9.
[35] U.S. Department of Health and Human Services, Office of the Surgeon General, Remarks by Vice Admiral Richard H. Carmona, U.S. Surgeon General at press conference to launch , "Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General," June 27, 2006.
[36] *Id.*
[37] U.S. Department of Health and Human Services, *Supra* note 25 at p. 9.

[38] Huang, Dr. Philip, Austin/Travis County Health and Human Services Department, Testimony before the *Senate Committee on Health and Human Services*, p. 3, (Austin, TX, September 8, 2010).
[39] *Id* at p. 5.

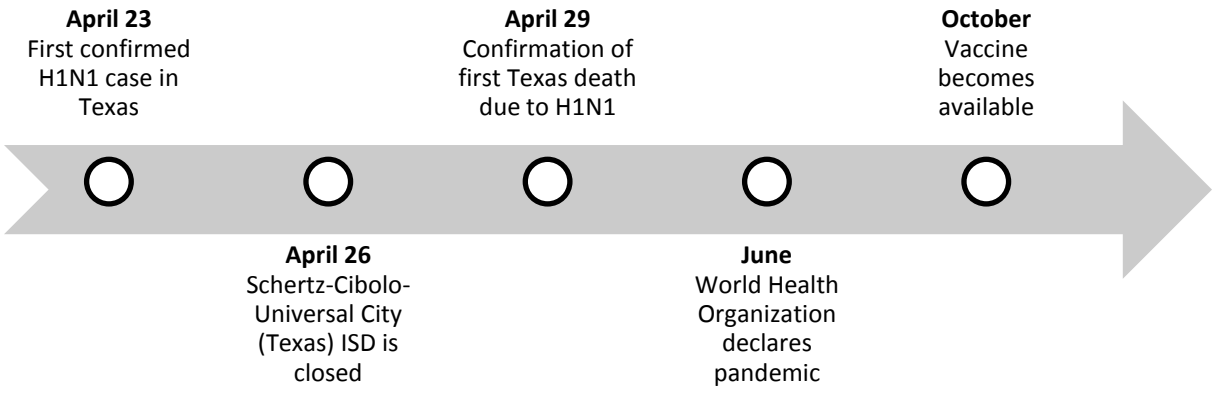
Interim Charge #8: *Study the state's ability to appropriately respond to the H1N1 influenza pandemic by examining issues related to vaccine distribution and capacity. Consider the benefit of providing the state's independent school districts and various health authorities with standardized protocols for issues including, but not limited to, vaccine administration, absenteeism and the cancellation of school and other school-related events. Assess the state's ability to track and record H1N1 vaccinations through the ImmTrac registry, and review statutes governing ImmTrac to increase the effectiveness and efficiency of immunization information systems.*

# Section I. Background

## H1N1 Impact in Texas

The H1N1 novel influenza virus affected communities across Texas beginning in the spring of 2009. The virus tested the preparedness of our state and local health departments, health care providers, and school districts throughout the state. Texas was one of the first states to confirm a case of H1N1 and the first to confirm a fatality. By the end of August 2009, Governor Perry had requested 850,000 antivirals through the Strategic National Stockpile, nearly 8,500 providers had registered with the state to receive the H1N1 vaccine, over 5,200 cases of H1N1 had been confirmed through surveillance testing at the Department of State Health Services (DSHS) state laboratory, and 29 people had died due to H1N1.[1] The World Health Organization (WHO) declared the event a "pandemic" in June 2009, an indication of the spread of the disease, not its severity.[2] While most individuals inflicted with H1N1 in Texas suffered only mild to moderate symptoms, the medically vulnerable -- those who were pregnant or suffered from a chronic illness such as asthma -- fared far worse after contracting H1N1.[3] Providers and health departments had to be prepared to identify and treat the full spectrum of symptoms in their patients.

### Figure 1: Timeline of Significant H1N1 Events in Texas, 2009[4]




## Pandemic Preparations

Prior to the H1N1 influenza pandemic, state and local public health officials in Texas undertook extensive preparedness activities in anticipation of such an event. Based on epidemiological evidence, experts believed that the next pandemic would most likely be an Avian influenza virus

stemming from Asia that would most profoundly affect the elderly, chronically ill and very young children. Instead, the H1N1 virus came from Mexico and primarily affected school-aged children and young adults ages 15-24.[5] Despite differences in planning scenarios and the actual virus that developed into a pandemic, prior planning and preparation served Texas well in the early days, weeks and months of the pandemic. In a recent report, Texas was named as one of the seven states most well-prepared to respond to a public health disaster. The ranking was based on Texas' achievement in 9 out of 10 preparedness indicators, including using a nationally compatible disease surveillance program, maintaining public health funding levels, and purchasing at least 50% of available stockpiled antivirals.[6]

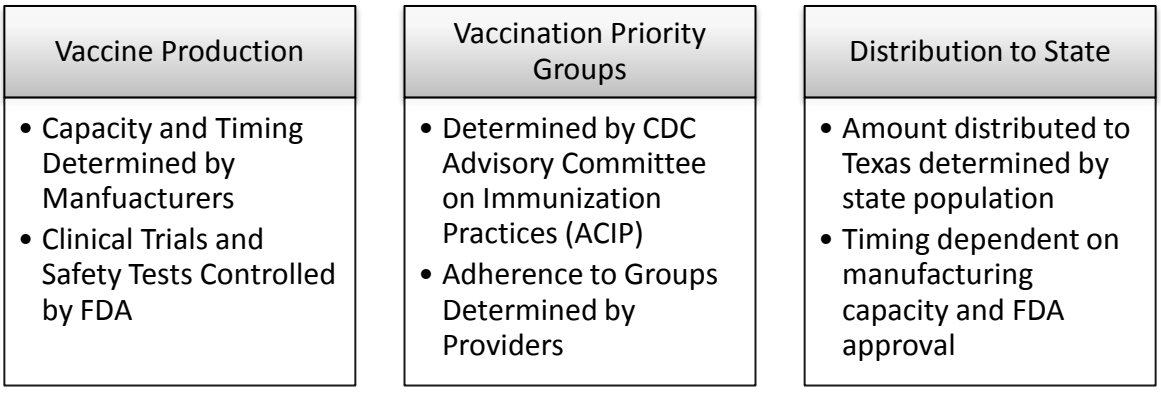
The H1N1 pandemic occurred in two "waves". The first wave occurred at the onset of the pandemic in the spring of 2009, and the second occurred in the fall of 2009.[7] By most official accounts, the threat of a third wave of H1N1 has passed, giving legislators and public health officials an opportunity to review the response to the pandemic and assess the success of vaccination and communication strategies. It also offers an opportunity to assess the usefulness of the statewide ImmTrac immunization registry, which was utilized during the height of the H1N1 pandemic to record immunizations.

# Section II: Analysis

## H1N1 Vaccination

Many outside factors affected the state's ability to respond to the pandemic, including vaccine production, decisions about priority groups, and vaccine distribution to the state. Details of these outside factors are depicted in Figure 2.

**Figure 2: H1N1 Vaccination Issues Not Determined at the State Level**




### Vaccine Development

*Seasonal Influenza Vaccine*

The seasonal influenza vaccine typically takes between six and nine months to develop. This process begins with research into what strains of the influenza virus are most likely to cause the illness in the next season by the WHO, the Federal Drug Administration (FDA), and the Centers

for Disease Control and Prevention (CDC). Based on this research and the recommendations of the FDA's Vaccine and Related Products Advisory Committee, the FDA determines the three strains that manufacturers should use to create the vaccine for the U.S. population. The closer the match between the three strains included in the vaccine and the strains that are circulating around the world prior to influenza season, the better the vaccine's ability to protect against influenza. Seasonal influenza vaccine manufacturers then submit their products to the FDA, which conducts rigorous testing for quality and safety.[8]

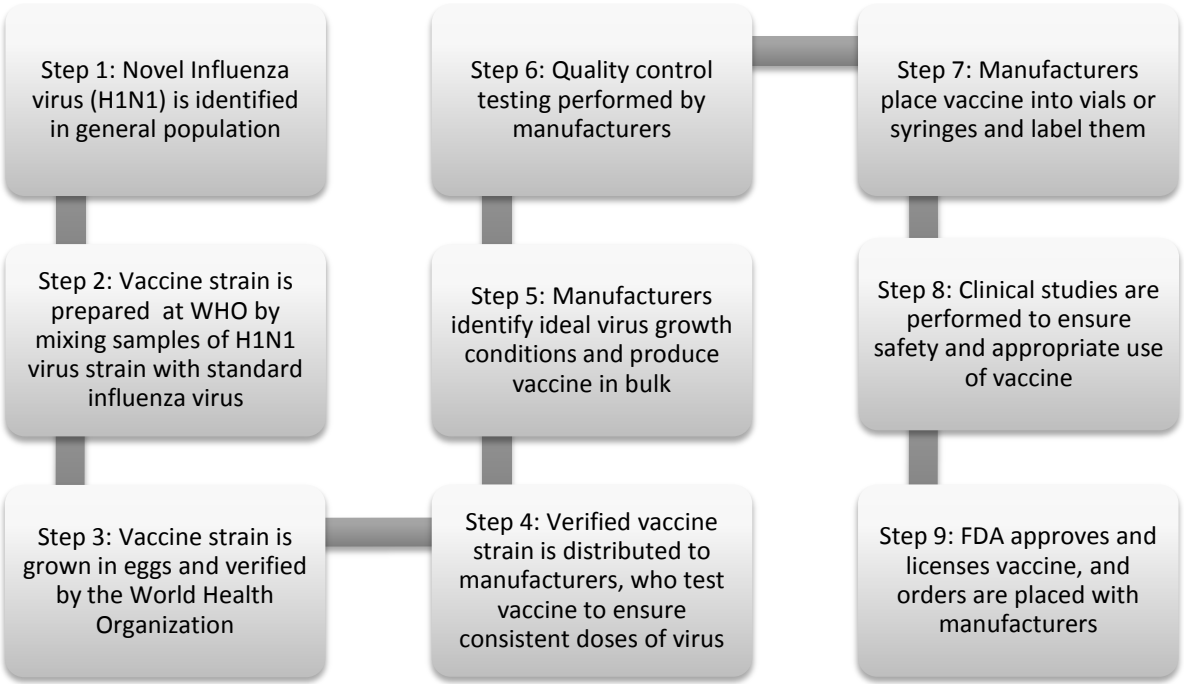
*H1N1 Influenza Vaccine*

The FDA and vaccine manufacturers were unable to utilize the normal seasonal influenza vaccine development process described above to create the H1N1 vaccine because it was a novel strain of the influenza virus. In contrast to the seasonal vaccine development process in which public health officials and manufacturers know that a virus will occur and roughly when it will appear, the H1N1 virus appeared suddenly and without warning. Since it was a completely unknown strain, the vaccine development process could not begin until the new virus was first identified in spring 2009. At that time, a vaccine strain was developed by mixing the H1N1 virus with seasonal influenza virus. From this point, the vaccine development process proceeded as normal (see Figure 3).[9] Due to the severity of many cases of H1N1, the need to control the virus, and the high demand for the vaccine, manufacturers rushed the process and the vaccine became available in small amounts within six months of the identification of the virus strain. Although there was frustration that the vaccine was slow to be developed and distributed to Texas, the process was actually greatly expedited in comparison to the typical seasonal influenza development process.

*Safety Concerns*

Due to the expedited timeline of the H1N1 vaccine development process, there were some concerns that the vaccine was not as rigorously tested and that perhaps the safety of the vaccine had been compromised. Despite the rushed timeline, however, the licensure and manufacturing of the H1N1 vaccine were the exact same as those used for seasonal influenza vaccine. Additionally, clinical and safety trials of H1N1 revealed that the incident of adverse reactions to H1N1 vaccination were no more severe or prevalent than the seasonal vaccine.[10] One manufacturer recall was issued for 800,000 pre-filled syringes of the vaccine intended for children ages 6 months to 3 years. However, the recall was because the shots had lost potency after they were shipped to Texas, not because of safety concerns.[11]

## Figure 3: H1N1 Vaccine Development Process[12]




**Vaccine Distribution**

*CDC Priority Groups*

The CDC's Advisory Committee on Vaccination Practices (ACIP) met in July 2009 to determine national Priority Groups that would serve as guidance for state health officials to determine who should receive the H1N1 vaccine first. These Priority Groups were based on disease patterns, the populations most at risk for severe illness, the groups experiencing high levels of hospitalizations and deaths, how much vaccine was expected to be available, and the timing of vaccine availability.[13] The original set of Priority Groups included an estimated 159 million people nationwide. Following are the original Priority Groups and the CDC justification for their inclusion:

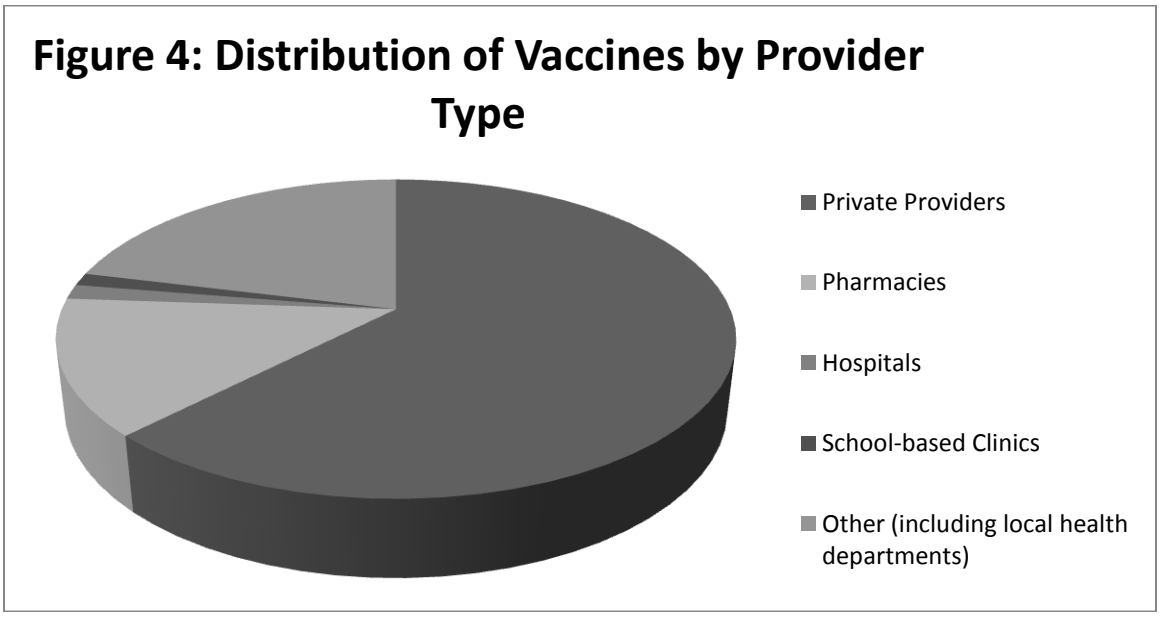
- **Pregnant Women** because they are at higher risk of complications and can potentially provide protection to infants who cannot be vaccinated;
- **Those living with or caring for children under 6 months** because younger infants are at higher risk of influenza-related complications and cannot be vaccinated. Vaccination of those in close contact with infants younger than 6 months old might help protect infants by "cocooning" them from the virus;
- **Health Care Workers (HCWs) and Emergency Medical Service (EMS) personnel** because infections among healthcare workers had been reported and this could be a potential source of infection for vulnerable patients. Also, increased absenteeism in this population could reduce healthcare system capacity;
- **Children from 6 months through 18 years of age** because cases of H1N1 influenza were seen in children who were in close contact with each other in school and day care settings, which increased the likelihood of disease spread, and

- **Young adults 19 through 24 years of age** because many cases of H1N1 influenza were seen in these healthy young adults and they often live, work, and study in close proximity, and they are a frequently mobile population;
- **People ages 25-64 with chronic medical conditions** because they are associated with higher risk of medical complications from influenza.

At the time these Priority Groups were announced in late July 2009, vaccines were still three months away from being available, and the CDC did not anticipate a vaccine shortage. However, they acknowledged that vaccine supply and demand could be unpredictable and included a narrowed list of Priority Groups as guidance for state and local health officials in case of a vaccine shortage. These revised Priority Groups only included pregnant women, those living with or caring for children younger than 6 months old, HCWs and EMS personnel with direct patient contact, children ages 6 months through 4 years, and children ages 5 through 18 with chronic medical conditions.[14]

*Provider Registration*

Although vaccines were not available to providers until fall 2009, providers began contacting DSHS at the onset of H1N1 in the spring to sign up for vaccines once they were made available. To handle these requests, DSHS created a web-based system to allow providers to register with the state and place orders for the number of vaccines they anticipated needing for their patients. The Vaccine Online Provider Registration System (VORS) allowed local health departments, private providers, community clinics, school-based health clinics, hospitals and pharmacists to register for the vaccine based on the geographical area they served and the number of patients in CDC Priority Groups they anticipated vaccinating. By January 1, 2010, 12,861 providers had registered. The distribution of the vaccines by provider type is seen in Figure 4.



Once the vaccine was available to Texas providers, DSHS determined how much vaccine providers would receive based on when they registered for the vaccine, how many patients in the CDC Priority Groups they anticipated being able to vaccinate, and their geographic location (in an attempt to ensure that vaccine was evenly distributed across the state). Prior to shipping vaccines to the providers, DSHS required providers to confirm that they still wanted the vaccine in the amount originally requested. Once confirmation from the providers was received, DSHS issued shipping instructions to a distributor to send the vaccine to the provider. The confirmation and shipping process took from 5 to 14 days depending on the volume and provider response time. Ultimately, 8.5 million doses of the vaccine were distributed to more than 10,800 registered providers.[15]

*Texas Distribution of Vaccines*

Texas officials were initially told by the CDC to expect 3.4 million doses of the H1N1 vaccine by mid-October 2009 and 15 million by January 2010. However, manufacturing delays reduced the actual amount of vaccines received in Texas to about 960,000 by mid-October.[16] Variability in processing times is normal in flu vaccine production as it is dependent on the manufacturer's ability to isolate the virus strain, grow the virus in egg embryos, and assure quality controls. This is why the seasonal influenza vaccine production process ranges from six to nine months.[17] These same uncertainties resulted in manufacturers overstating to the CDC the volume of vaccine that they would be able to deliver by the fall of 2009. The federal government ordered 250 million doses of the H1N1 vaccine and expected 100 million by early November 2009, but only 32 million doses had actually been distributed to them by November 5. Although the delay in receipt of the vaccine was due to the unpredictable biology of influenza viruses and not human error, providers and citizens were frustrated with the discrepancies between the level of vaccines they were expecting and the numbers they actually received.[18] While people falling into one of the CDC Priority Groups were being urged by their providers, state officials, and federal guidance to seek vaccination, there was no vaccine available to them. In order to ration the vaccines as they slowly became available, DSHS developed a Texas-specific distribution plan based on several factors:

- Guidance on vaccination Priority Groups from the CDC's ACIP;
- Epidemiological evidence gathered in Texas;
- Estimates of available vaccines and the formulation of those vaccines; and
- Input from stakeholders.[19]

The first 142,400 doses of the vaccine arrived in Texas in early October and came in a FluMist formula that is only approved for use in people ages 2 through 49 years of age who are not pregnant and do not have chronic health conditions. Based on these specifications and Priority Group guidance from the CDC to vaccinate young children, DSHS distributed the original shipment of FluMist vaccines to local health departments and other providers registered through the VORS System who serve 2 and 3 year olds.[20] On October 11, Texas received 363,800 doses of the vaccines including 235,000 doses of the shot and 128,800 doses of FluMist. In addition to continuing to allocate FluMist doses to providers treating 2 and 3 year olds, DSHS distributed these vaccines to providers treating pregnant women, 4 year old children, children ages 5-18 with a high risk of medical complications and HCWs who care for these groups.

As manufacturing issues were resolved over the next two months, DSHS began receiving more doses of the vaccine and added all HCWs with direct patient contact, children ages 6 months to one year, and adults with high risks of medical complications to their distribution groups. On December 11, 2010, H1N1 vaccines were made available to everyone who wished to be vaccinated, regardless of whether they fell into one of the CDC's Priority Groups.[21]

**Local Vaccination Efforts**

Local health authorities utilized different approaches to vaccinate citizens based on their specific population base, vaccine availability, and the extent to which vaccines were available through private providers in their communities. Many formed partnerships with pharmacies, churches, schools, and community-based organizations to educate citizens about the benefits and availability of the vaccine. Mass Vaccination Clinics served as one of the most useful tools for local health departments during the height of the pandemic. These clinics took different forms depending on the community, but tended to be walk-in based and open at off hours, such as before and after typical office hours. They served as a valuable resource to vaccinate people with inflexible work schedules and those who were uninsured.[22]

**Challenges Related to Vaccination**

There are areas related to vaccine distribution that could be improved in future responses. Some of these areas, such as the determination of CDC Priority Groups, and the vaccine production difficulties faced by manufacturers, cannot be impacted by state policy or practice. Others, however, can be addressed at least partly at the state level to ensure better responses to public health issues in the future:

*Communication with Providers about Vaccine Availability*

The information DSHS received from federal health officials with the was constantly changing based on the development of the pandemic and the availability of vaccines. Although efforts were made to communicate these updates to providers, some expressed frustration about the lack of information regarding the availability of vaccines and how distribution of the vaccine would be handled.[23] DSHS has worked to establish regular lines of communication with the provider community so that information flows freely between state and local leaders. Continuing to re-evaluate these lines of communication and sending a consistent message during disasters about vaccine availability and distribution guidelines should be an ongoing goal.

*Vaccinating Health Care Workers*

HCWs, especially those with direct patient contact, are at higher risk for exposure to and possible transmission of vaccine preventable diseases.[24] During the pandemic, HCWs were in frequent contact with those infected with H1N1, as well as with those suffering from chronic conditions who were at increased risk of contracting H1N1. Due to this unique position, the CDC recommended that HCWs with direct patient contact be vaccinated as part of their Priority Groups.[25] They were also included in DSHS's Texas-specific target groups, yet they had a low rate of H1N1 vaccination, at only 22.3%.[26]

In New York state, the Commissioner of the State Department of Health promulgated regulations in August 2009 that HCWs and volunteers with direct patient contact would be required as a precondition of employment (and annually thereafter) to be vaccinated against seasonal and H1N1 influenza. The regulations also required health care facilities to supply vaccinations at no cost to employees and volunteers. Only staff who could show that they should not be vaccinated for medical reasons were exempted from the requirement. The regulations also allowed the state to suspend the requirements in case of limited supply of the vaccine. Supply of the H1N1 vaccine was limited, and on October 22, 2009, New York Governor David Patterson suspended the vaccine regulations due to a limited supply. Shortly before this suspension, several provider groups and HCW unions sued to prevent enforcement of these regulations. On February 19, 2010, the New York Supreme Court dismissed the lawsuits because the regulation had been withdrawn by the Governor due to limited supply.[27] The question remains whether the state of New York will be able to enforce such regulations for vaccinations needed during future pandemics or other disease outbreaks.

Texas does not mandate vaccination of HCWs, but some health care facilities in Texas have achieved high HCW vaccination rates without mandates. At Baylor Health Care System facilities, for example, the level of HCW vaccination against H1N1 was close to 85%. This is due to the System's practice of educating employees about the risks of transmitting the virus not only to their patients, but also unknowingly transmitting it to their families. Leaders of the Baylor System also served as an example by being vaccinated against H1N1 as soon as the vaccine was available and ensuring vaccines were readily available to employees that fell into the CDC Priority Groups.[28] Additionally, all accredited public hospitals in Texas must offer all CDC-recommended vaccinations to their employees and are required to report vaccination rates and the reasons for employee refusals of vaccines.[29]

The responsibility of encouraging higher take-up rates must be shared by state and local governments, as well as the employers of HCWs. Each individual hospital and provider should strive to create a culture in which vaccination is seen as a way to protect the HCWs, their families, and the patients they serve.

*Provider Registration System*

The VORS system was created quickly to allow providers to pre-register for vaccines. Several issues with the system were reported by providers, including:

- Error messages received after registering;
- Lack of feedback to providers after registering;
- No verification of vaccine orders;
- Misclassification of a private provider as a hospital, or vice versa; and
- Limited communication with providers about availability of vaccine in their area.[30]

DSHS is continuing to streamline and develop the VORS system so that it may be useful in future public health emergencies involving a vaccine. DSHS should ensure that provider groups be included in discussions that inform what advances and changes are made to the VORS system.

## Issues Relating to Independent School Districts and Local Health Departments

DSHS played a major role in organizing the response to the H1N1 pandemic at the state level and served as a liaison between local health departments, ISDs and federal agencies giving guidance such as the CDC and the U.S. Department of Health and Human Services. Local partners served important functions during the pandemic by monitoring epidemiological conditions on the ground and reporting them to DSHS, encouraging local citizens to take precautions to protect themselves and their families from the spread of the disease, and utilizing the best local information available to make decisions about school closures.

One of the most significant ways the state managed the H1N1 pandemic was through consistent communication efforts with local stakeholders. DSHS organized bi-weekly conference calls with local health partners, health care provider organizations, legislative offices, and executive offices, including the Governor. These conference calls informed stakeholders about the most current status of the pandemic and the state's response activities. The Texas Education Agency (TEA) provided an important link between local school districts and DSHS by participating in these calls and encouraging school nurses to participate.

*School Closures and Absenteeism*

The DSHS Regional Health Directors in the 11 Health Service Regions throughout Texas worked with Superintendents to provide CDC guidance on school closure issues. However, the decision to close a school or a district was ultimately made by the school board with guidance from the state and/or local health department.[31] Initial guidance issued by the CDC on May 1, 2009 recommended that communities with confirmed cases of H1N1 should consider adopting school dismissal and child care closure measures, including closing schools for up to 14 days. Many schools across the state did close in the first days of the spring of 2009, when the severity and reach of the virus was still unknown. The first entire district to close in the nation was Schertz-Cibolo-Universal City Independent School District (SCUCISD) in Guadalupe County, Texas. The first two confirmed cases of H1N1 were in children who attended school in SCUCISD, and their eight-day closure and the response initiated at the local level in that community serve as an example of what schools across the state undertook. Immediately following the closure of the district, school administrators recognized the importance of communicating immediately and frequently with the community. They used various techniques including: an automated calling system, traditional phone trees, web page postings, podcasts, a Twitter account to answer questions from students and parents, streaming video of school board meetings online, and student lessons posted online to prevent them from falling behind.[32]

As new information about the severity of the virus quickly became known, the CDC issued new guidelines on May 5, 2009 that did not recommend school closure and instead recommended implementing measures that would focus on keeping all students, faculty, and staff with symptoms home from school while continuing to operate schools on a regular schedule. The CDC determined that, as the virus quickly spread and H1N1 became common in many communities, school closures and other social distancing measures were not effective and disrupted learning without bringing about significant benefits to public health.[33]

Many schools experienced high rates of absenteeism among students that had contracted the virus, creating confusion and anxiety over whether schools would lose funding for their high absentee rates. Texas' public school funding formulas are based in part on attendance rates and school suffer financially if their attendance rates are unusually high. For example, if a student misses 9 days during the 180-day school year, the district loses 5% of the funding a student with perfect attendance would generate. In response to school administrators' concerns over losing funding due to high absentee levels associated with H1N1, TEA Commissioner Robert Scott issued guidance to school districts on how to apply for waivers that would grant schools immunity from these penalties.[34]

*School Lunches and Breakfasts*

Another significant issue faced by schools who were forced to close or simply had high absentee rates during the H1N1 pandemic was how to ensure that low-income children relying exclusively on school lunches and breakfasts for their meals were still being fed. The Texas Department of Agriculture (TDA) worked closely with TEA and DSHS to provide reimbursable meals during the H1N1 pandemic. They achieved this by allowing School Food Authorities and community organizations to offer meals in non-congregate settings and reimbursing them using funding allocated for the Summer Food Service Program. These organizations applied to TDA for waivers that would allow them to serve meals at non-school sites.[35] 189 School Food Authorities were approved to serve meals during closures due to H1N1 at over 2,800 feeding sites. Fortunately, most of these waivers did not need to be utilized as school closures were not common in Texas.

*Lack of school nurses at Independent School Districts*

For those children who were not insured and did not live near one of the local health department's Mass Vaccination Clinic sites, School-Based Health Clinics served as vaccinators during the H1N1 pandemic. Although only about 2% of registered vaccine providers in Texas were schools, the schools played other vital roles during the pandemic.[36] They were the first line of defense against the spread of the virus between adolescents, who turned out to be the most severely affected by the virus. They also acted as educators on non-pharmaceutical measures such as hand-washing, using hand sanitizer, and social distancing. Many school districts in Texas do not have a school nurse on campus, much less one that serves the school full time. Although school districts currently face dire fiscal situations, a long-term public health goal of the state should be encouraging each campus to have a school nurse on staff to serve as a liaison during public health crises such as H1N1.

*Standardized Protocols*

Each disaster that Texas faces in the future will present new challenges and necessitate its own protocols and responses from those at all levels of government. Responses should be crafted with these unique challenges in mind and will depend on what portions of the population are most adversely affected and what measures are needed to mitigate the disaster. During the H1N1 pandemic, rapidly changing conditions and guidance from federal and state partners required flexibility at the local level. In general, local level decisions should be made by those best placed to assess the epidemiological conditions and preparedness levels within their

communities. However, the state should continue to ensure that the infrastructure and manpower is in place that is necessary to respond to any type of disaster. Public Health officials should act immediately when a disaster strikes to develop standardized ways to communicate guidance to local health departments and ISDs on issues such as school closures, dealing with high levels of absenteeism, and how to orderly administer vaccines. Maintaining our current level of preparedness and ensuring that lines of communication between local and state partners remain open will allow for more efficient and timely responses in future disasters.

## ImmTrac

Throughout the H1N1 Pandemic, providers who administered the H1N1 vaccine were required to submit a record of each vaccine given to the statewide immunization registry, ImmTrac. This experience provided an opportunity for a review of the policies governing the ImmTrac registry as well as to identify opportunities for improvements.

### Basics of ImmTrac

The ImmTrac registry was created in 1996 as the Texas Immunization Registry. In 1997, the 75th Legislature passed HB 3054 (Berlanga), authorizing DSHS to operate the registry. It provides a free, confidential way for providers to consolidate and store children's immunization records. The system is opt-in, meaning that written consent is required for DSHS to maintain immunization records. [37]

When health care providers administer immunizations to a child, they obtain consent from the parent or caregiver to create or add to the ImmTrac record for that child. Each record includes the child's name, date of birth, address, the name of the parent or guardian, the date and dosage of each vaccine given, and the name of the provider who administered the vaccine. The system allows providers authorized to use ImmTrac to view the immunizations already administered to a child to avoid duplicate immunizations when a child relocates or begins seeing a new provider.

### Advances in the ImmTrac Registry

Since its inception, the scope and purpose of ImmTrac has expanded from allowing for the storage of children's records to serving as a tracking and reporting tool for children, adults, first responders and their families, and any persons immunized in the course of a disaster. During the 80th Legislative session, SB 1186 (Nelson) was passed as an amendment to SB 11 (Carona).[38] This measure required that all immunizations and antivirals administered as part of a response to a public health emergency or declared disaster be recorded in ImmTrac. It also allowed first responders and their families to be included in the registry. SB 1409 (Shapleigh), passed by the 81st Legislature, expanded the definition of first responder to include any federal, state, local, or private personnel who is authorized to respond to a disaster, including certain individuals that provide support services during the prevention, response, and recovery phases of a disaster. This consequently expanded the number of people who could opt-in to the registry.[39]

The 81st Legislature also passed two additional bills that greatly expanded the scope and capabilities of ImmTrac. Historically, records in ImmTrac were expunged upon a child's 18th birthday. SB 346 (Nelson) allowed 18 year-olds and their parents to consent to having their immunization records maintained in the system beyond the age of 18.[40] This allowed young adults to maintain their records and use them for entry into the military, college, and health

professions, all of which often require proof of certain immunizations. The 81st Legislature also passed SB 347 (Nelson), which allowed DSHS to share and receive immunization records with health departments in other states during disasters that involve evacuation.[41] This capability is crucial to avoid duplicative immunizations when people fleeing disasters cross state lines.

Since its inception, ImmTrac has served as a repository of immunization histories for:

- Over 83 million immunization records ('record' refers to one dose, or shot, of a vaccine);
- Over 6.3 million clients under the age of 18;
- Over 2.2 million clients under the age of 6;
- Over 7,800 first responders and family members of first responders;
- Over 18,000 antivirals entered as part of disaster responses; and
- 2,379 adults who have opted to maintain their immunizations in ImmTrac beyond the age of 18.[42]

During the H1N1 pandemic, providers were required (pursuant to SB 11, 80th Legislature) to enter H1N1 vaccines they administered to individuals. This resulted in 1.8 million immunization records being recorded during the pandemic. Providers are given 30 days to report immunizations to ImmTrac, although the typical lag time in reporting H1N1 vaccines was about one week.[43]

**Necessary Improvements**

Despite its successes and advancements, the ImmTrac system requires further updates and changes to be more user-friendly and useful.

*Compatibility with Electronic Medical Records*

ImmTrac is currently not compatible with Electronic Medical Records (EMRs), a major roadblock to its widespread adoption by physicians, who are increasingly reliant on EMRs and desire the ability to interface between these two technologies in real time. This incompatibility requires providers to enter immunization data into two systems separately, a costly waste of staff time and a disincentive to using ImmTrac. Although providers are statutorily required to submit immunization records to the registry, there are no penalties for failing to do so, and many providers choose not to. This is evidenced in part by the discrepancy between the number of H1N1 vaccines that were administered by providers registered through the VORS system (8.5 million) and the number of those vaccines that were reported to ImmTrac (1.8 million).[44] One of the main reasons cited by providers is the EMR compatibility issue. Compatibility with EMRs will only be possible if DSHS brings ImmTrac into Health Level 7 compliance.[45] Health Level 7 (HL7) refers to a computer language specifically designed for exchanging health information. It is nationally accepted as the standard for exchanging health-related information between medical applications in a way that ensures privacy and maximizes efficiency.[46] Bringing ImmTrac into HL7 compliance would allow information to be exchanged seamlessly between EMRs and ImmTrac, providing an incentive for providers adhere to the statutory requirement that they participate in the ImmTrac registry. In order to bring ImmTrac into HL7 compliance, significant technological changes would have to be made to the current operating system, which is 15 years old and requires frequent and costly maintenance. The most cost-effective way to make these technological updates would be to replace the existing antiquated system with a new operating system, at an estimated $2.5 million[47].

*Increasing Userability*
Bringing the ImmTrac system into HL7 compliance would also allow for improvements to the user interface. In addition to eliminating the need for providers to enter immunization into both EMRs and the ImmTrac system, providers would also gain the ability to upload records into the ImmTrac system in various ways, including from remote locations. This would allow physicians administering vaccines at evacuation shelters during a disaster, for example, to update the system in real-time.[48]

A userability improvement to the ImmTrac registry that does not require HL7 compliance is currently underway at DSHS. In July 2010, the agency announced that it is implementing a new immunization scheduler in ImmTrac. The scheduler allows users to generate up-to-date immunization recommendations for ImmTrac clients based on the immunizations currently stored in that client's record. The system's previous immunization scheduler tool was outdated and did not include vaccinations against seasonal influenza, human papillomavirus (HPV), rotavirus, and combination vaccines such as DTaP and Tdap (protecting against diphtheria, tetanus, and pertussis). The new scheduler follows the CDC ACIP's recommended vaccination schedule.[49]

*Incorporating Best Practices into ImmTrac*
The guidelines for immunizations recommended by the CDC's ACIP are very complex. Each vaccination comes with rules that providers must follow in order to comply with best practices, and these national recommendations are issued twice a year. While several other states have incorporated these best practices into their immunization registries through pop-up windows that alert providers to the vaccine-specific ACIP recommendations, Texas has not yet taken this step[50]. An example of this feature can be seen in the case of a child who has received a combination vaccine at one provider's office and arrives at another provider's office for the next round of immunizations that offers a different type of combination vaccine. If best practices were incorporated into the ImmTrac registry, the second provider would be alerted about what the proper dose is, the timeline for vaccinations, and the best practice guidelines developed by ACIP about how to proceed with immunizing the child. DSHS is currently looking into how to incorporate a best practice feature into the ImmTrac system.

# Section III: Conclusion

Texas was one of the first states to observe confirmed cases of H1N1 in the spring of 2009. Unlike the pandemic experts were predicting -- one that would begin in Asia and eventually reach Texas -- the H1N1 influenza virus started much closer to our own borders. This required health officials to adapt quickly. Throughout the pandemic, vaccinations played an important part of protecting citizens against the spread of the disease. Manufacturing setbacks resulted in delays for providers seeking the vaccine, and many who sought the vaccine were unable to obtain it. Schools and local health departments were on the front lines in responding to the pandemic and relied on guidance from state public health officials on how to handle issues such as vaccination administration and school closures. In future pandemics and other public health disasters, it will be crucial to keep the lines of communications open between these key groups and to educate the general public with information in a timely and accurate manner. The

ImmTrac system played an important role for recording and tracking these vaccinations, and improvements can be made to both the vaccination registration system used during the pandemic, as well as to the ImmTrac system. State health officials should work with providers to identify necessary improvements to this system.

## Section IV: Recommendations

1. **Replace current ImmTrac system technology to facilitate data exchange between ImmTrac and Electronic Medical Records (EMRs).**

2. **Implement improvements to the user interface for ImmTrac to improve data input and lookup for records.**

3. **Build best practices tools into the ImmTrac system.**

---

[1] Lakey, Dr. David, Department of State Health Services, "Novel H1N1: Lessons Learned, Pandemic Planning and Preparations." Legislative Briefing, September 16, 2009 at 11-13.
[2] "Pandemic" refers to a disease outbreak occurring over a wide geographic area and affecting an exceptionally high proportion of the population.
[3] Associated Press, "1 in 4 Hospitalized Swine Flu Patients Put in ICU", October 8, 2009.
[4] Lakey, Dr David, Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, Panel 1, (Austin, Texas, February 24, 2010), at 2-4.
[5]Valadez, Dr. Adolfo, Department of State Health Services, "Texas Pandemic Influenza Update." Presentation to the Disaster/Emergency Preparedness Committee of the Governor's Emergency Medical Services and Trauma Advisory Council August 19, 2009, at 7.
[6] Trust for America's Health and the Robert Wood Johnson Foundation, "Ready or Not? 2009: Protecting the Public's Health from Diseases, Disasters, and Bioterrorism", December 2009.
[7] Lakey, *supra* note 1, at 17.
[8] Hernandez, Rosalinda, Department of State Health Services. "FW: 2605: Development process and timeline for the seasonal influenza vaccine." Email sent to the author. July 2, 2010.
[9] World Health Organization. "Pandemic Influenza Vaccine Manufacturing Process and Timeline: Pandemic (H1N1 2009 Briefing Note 7". Available: http://www.who.int/csr/disease/swineflu/notes/h1n1_vaccine_20090806/en/index.html. Accessed: August 6, 2009.
[10] CDC Mortality and Morbidity Weekly Report, "Safety of Influenza A (H1N1) 2009 Monovalent Vaccines", Vol. 58 (Early Release), December 4, 1009.
[11] Stobbe, Mike, Fort Worth Star-Telegram, "Some Swine Flu Shots for Kids are Recalled", December 16, 2009.
[12] World Health Organization, *supra* note 9, at 1.
[13] CDC Advisory Committee on Immunization Practices 2009 H1N1 Vaccination Recommendations. Available: www.cdc.gov/h1n1flu/vaccination/acip.htm. Accessed: July 17, 2009.
[14] Centers for Diseases Control and Prevention (CDC) Press Release, July 29, 2009.
[15] Sims, Jack, Department of State Health Services. "FW: 2605: Development process and timeline for the seasonal influenza vaccine." Email sent to the author. October 28, 2010. The discrepancy between the number of providers who registered for the vaccine and the number who actually received it is due to those providers who either determined that there would not be demand for the vaccine among their patients, or declined to sign the CDC agreement, stating that they would adhere to federal guidelines on H1N1 vaccine distribution, handling, and reporting prior to receiving any vaccine.
[16] Department of State Health Services Press Release, "Texas H1N1 Vaccine Update", October 20, 2009.
[17] Valadez, Dr. Adolfo, Department of State Health Services. "FW: 2605: Development process and timeline for the seasonal influenza vaccine." Email sent to the author. July 6, 2010.
[18] Brown, David, Washington Post, "Flu Outrunning Vaccine, Experts Say", November 5, 2009.

[19] Lakey, *supra* note 4, at 22.
[20] Department of State Health Services Press Release, "DSHS Provides Texas H1N1 Vaccine Update", October 6, 2009.
[21] Jacobson, Sherry, Dallas Morning News, "State Opens Swine Flu Shots to All", December 11, 2009
[22] Carlo, Dr. John, Dallas County Department of Health and Human Services, *Testimony before the Senate Committee on Health and Human Service*, (Austin, Texas, February 24, 2010), p. 13.
[23] Murphy, Dr. Donald, Texas Medical Association, *Testimony before the Senate Committee on Health and Human Services*, (Austin, Texas, February 24, 2010).
[24] CDC Morbidity and Mortality Weekly Report, "Immunization of Health-Care Workers: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC)", Vol. 46 (RR-18), December 26, 1997.
[25] Lakey, *supra* note 4, at 23.
[26] Carlo, *supra* note 22, at 2.
[27] Public Health Reports, "Vaccinating the Health-Care Workforce: State Law vs. Institutional Requirements", Volume 125, July-August 2010.
[28] Carlo, *supra* note 22, at 2.
[29] Rose, Denise. Texas Hospital Association. "Re: HCW Vaccination". Email to the author, October 28, 2010.
[30] Murphy, *supra* note 23, at 1.
[31] Lakey, Dr David, Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, Panel 2, (Austin, Texas, February 24, 2010).
[32] Pustka, Dr. Belinda, Retired Superintendent of Schertz-Cibolo-Universal City ISD**,** *Testimony before the Senate Committee on Health and Human Services*, Panel 2, (Austin, Texas, February 24, 2010), p. 5.
[33] Centers for Disease Control and Prevention (CDC) Media Statement "School Closure Guidance", May 5, 2009.
[34] Texas Education Code, Chapter 25, Admission, Transfer, and Attendance.
[35] Commissioner Todd Staples, Texas Department of Agriculture, Letter to School Food Authorities, August 31, 2009.
[36] Lakey, *supra* note 31, at 10.
[37] House Bill 3054, 75th Regular Session, 1997 (Berlanga).
[38] Senate Bill 1186, 80th Regular Session, 2007 (Nelson); Senate Bill 11, 80th Regular Session, 2007 (Carona).
[39] Senate Bill 1409, 81st Regular Session, 2009 (Shapleigh).
[40] Senate Bill 346, 81st Regular Session, 2009 (Nelson).
[41] Senate Bill 347, 81st Regular Session, 2009 (Nelson).
[42] Lakey, Dr David, Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, Panel 3, (Austin, Texas, February 24, 2010).
[43] *Id*. at 12.
[44] Sims, Jack, Department of State Health Services. "FW: 2605: Development process and timeline for the seasonal influenza vaccine." Email sent to the author. July 22, 2010.
[45] Lakey, *supra* note 42, at 14.
[46] Dragsbaek, Anna, Texas Immunization Partnership, "Necessary Technical Enhancements to ImmTrac" Informational Briefing, March 10, 2010, at 1.
[47] Department of State Health Services, Legislative Appropriations Request, 2012-13 Biennum, Exceptional Item Request by Strategy.
[48] Dragsbaek, Anna, Texas Immunization Partnership, Testimony before the Senate Committee on Health and Human Services, (Austin, Texas, February 24, 2010), at 7.
[49] Department of State Health Services, "Frequently Asks Questions (FAQs for ImmTrac's 2010 Immunization Scheduler Enhancement", June 29, 2010.
[50] Dragsbaek, *supra* note 46, at 3.

Interim Charge #9: *Study current state health care quality improvement initiatives in Texas, including statewide health-care associated infection and adverse event reporting, reimbursement reductions in the Texas Medicaid program for preventable adverse events, potentially preventable readmissions identification, health information technology implementation, pay-for-performance programs, and other initiatives aimed at improving the efficiency, safety, and quality of health care in Texas. Identify statutory changes that may build upon efforts to improve quality of care and contain health care costs in Texas. Study policies that encourage and facilitate the use of best practices by health care providers including the best way to report and distribute information on quality of care and the use of best practices to the public and to promote health care provider and payment incentives that will encourage the use of best practices. The study/recommendations could also include assessing the best way to bring provider groups together to increase quality of care, the use of best practices, and reduce unnecessary services.*

# Section I. Background

Rising health care costs are consuming larger portions of federal and state budgets, taking funding away from other public priorities; preventing employers from providing their employees with other benefits such as increased wages; and leaving many families in medical debt. Outpacing both inflation and income growth, health care costs have reached unsustainable levels:

- In 2008, national health expenditures surpassed $2.3 trillion, three times more than in 1990 and eight times more than in 1980.[1]
- Health care expenditures account for roughly 16 percent of the U.S. gross domestic product (GDP) and are projected to reach 19.3 percent of GDP by 2019.[2]
- Health care spending per capita in the U.S. is approximately $7,500 per year, roughly one-third more than other industrialized countries.
- Over 60 percent of all bankruptcies are filed for medical reasons.[3]
- Texas Medicaid currently accounts for nearly one-quarter of the state's total budget.
- For fiscal years 2010-11, the state appropriated $16.3 billion in General Revenue for operation of the Medicaid program, a $1.3 billion increase over fiscal year 2008-09 funding levels.[4]
- Approximately two million additional Texans are expected to enter the Medicaid program under federal health care reform at a cost to the state of $27 billion for fiscal years 2014-23.[5]

These trends, coupled with the recent economic recession and state budget shortfall, have made controlling health care costs a critical public policy priority in Texas. To control health care costs, it is important to understand some of the factors driving these costs.

Aging Population

Like the rest of the country, Texas' population is aging. The state's 65 and older population is expected to double, and possibly triple, between 2010 and 2040. By 2040, this group is estimated to account for nearly one-fifth of the state's total population, compared to one-tenth of the current population.[6] Health care costs are greater in this group because of chronic diseases and long-term care services and supports, which are predominately covered by the Medicaid program.

Chronic Disease

In addition to the state's elderly population, chronic diseases, many preventable, are becoming more prevalent among the general population as well. Treatment for chronic diseases is costly, accounting for three-quarters of total U.S. health care spending.[7] If demographic projections for Texas hold true, its health care system will reach crisis levels by 2040:

- Three out of four deaths in Texas are caused by chronic disease.[8]
- The number of obese adults in Texas will increase from 5.3 million in 2010 to nearly 15 million, or one-third of the projected population, by 2040. [9]
- By 2040, a quarter of Texas adults will have diagnosed diabetes.[10]

Lifestyle choices can reduce the risk of some chronic diseases. For example, research has shown that tobacco use is a risk factor for a number of different cancers, cardiovascular diseases such as stroke and high blood pressure, and lung disease.[11]

Waste

Despite U.S. spending levels, comparisons between the U.S. and other industrialized countries consistently indicate that health care quality and patient satisfaction with care is no better, and sometimes poorer, in the U.S.[12] Some experts believe this is due to health care waste and estimate that nearly one-third of health care costs in the U.S. are unnecessary and result from waste such as administrative inefficiency, unnecessary treatment, and medical errors.[13] While some of these result only in increased costs, others may result in serious patient injury or even death. Reducing health care waste provides a significant opportunity to decrease excess costs while improving health care quality for Texans.

**Health Care Outcomes**

Controlling health care costs and improving the overall quality of care will require all Texans, including health care providers, patients, and payers (e.g., private health insurers, government health care programs), to take an active role and be held accountable for their health care behaviors. Providers will need to coordinate amongst themselves and with their patients to increase efficiency, reduce duplicative services, and prevent medical errors; patients will need to adhere to their treatment plans, utilize care in the most appropriate setting available, and make healthy choices; and payers will need to align payments and incentives in a way that encourages these positive behaviors.

It is widely agreed that the current health care payment system fails to promote positive health care behavior, and instead, contributes to growing health care waste. Health care services are predominately paid “fee-for-service” which bases payment on the quantity of services provided rather than whether the services resulted in positive health outcomes for the patient. This payment method has inadvertently created a health care system that rewards providers for high-cost, high-volume services and financially penalizes high quality, efficient providers.

Historically, efforts by payers to improve quality and reduce costs have focused on how care should be delivered. However, this "one size fits all" approach can stifle innovative delivery models, and typically leaves the patient out of the equation. Recently, health care experts have suggested a number of health care delivery models to reduce costs and improve quality, including accountable care organizations (ACOs), patient-centered medical homes, and

integrated care models. These models may have potential to improve quality and efficiency; however, rather than focusing on the health care delivery model, payers who want to move toward a "performance-based" payment system should instead incentivize the patient outcomes that result from high quality and efficient care (e.g., low error rates, reduced hospital readmissions). Under this approach, payers establish the expectations, and give providers the flexibility to determine the best way to reach them.

## Rewarding Positive Outcomes through Payment System Reform

Texas policymakers will face a number of budget challenges in the upcoming legislative session, one of which will be controlling Medicaid costs. As discussed previously, there are opportunities for reducing costs while improving quality.

Over the last several sessions, the Legislature has passed a number of initiatives to set the groundwork to transition the way the state pays for services under Medicaid and the Children's Health Insurance Program to a performance-based system. Recent state initiatives include public reporting of healthcare-associated infections and preventable adverse events, Medicaid payment reductions for preventable adverse events, and identification of potentially preventable Medicaid readmissions. Section II discusses these initiatives in more detail. According to Dr. Charles Bell[14] in his April presentation to the Senate Committee on Health and Human Services, "these changes are expected to produce healthier outcomes for the individuals eligible for these programs and over the long term reduce high cost health care expenditures."[15]

To continue the transition to performance-based Medicaid and CHIP reimbursements, policymakers should direct the Health and Human Services Commission (HHSC) to develop outcome measures that promote safe and efficient health care behaviors by providers and patients. Once fair and objective outcome measures are developed, HHSC should apply them to Medicaid and CHIP payment systems.

An appropriate starting point for HHSC is to develop outcome measures aimed at reducing known waste in the Medicaid program, such as:

- unnecessary emergency room visits;
- unnecessary hospital admissions;
- potentially preventable readmissions;
- potentially preventable complications;
- unnecessary or duplicative diagnostic tests and medications; and
- fraud.

To ensure that these outcome measures are fair and meaningful, health professionals must play an integral role in their development. When developing outcome measures, HHSC should be required to consult with an advisory committee composed of physicians, nurse practitioners, hospital representatives, and consumers, like the Medicaid/CHIP Quality Based Payment Workgroup created by HHSC earlier this year. Any outcome measures developed should take into account factors that are outside of a provider's control such as severity of the illness and patient non-compliance.

A variety of health care quality projects, many initiated by health care provider groups, professional associations, and insurers, are underway across the state. While the scope of this report will focus primarily on quality initiatives within Texas Medicaid and CHIP, the overarching goal is to develop objective outcome measures that can be used regardless of the specific service delivery model. As a result, HHSC will retain flexibility to collaborate with providers using innovative delivery models to improve health care efficiency, safety, and quality.

# Section II. Analysis

This section outlines six major categories of health care waste, existing state programs aimed at decreasing this waste, and opportunities for the state to reduce health care waste in the future.

## Unnecessary Emergency Room Visits

According to a recent study published in *Health Affairs*, approximately 17 percent of emergency room (ER) visits in the U.S. are unnecessary, meaning the visits involved a condition that could have been treated at a clinic or urgent care center, and the visit occurred during hours that such an alternative was available. Conditions include lacerations, minor infections, fractures, and strains. These unnecessary visits amount to approximately $4.4 billion in health care costs annually.[16]

An efficient health care system is one in which patients receive the right care at the right time in the right setting. There are several reasons a patient may choose to seek care at the ER rather than a more efficient health care setting:

- A patient may not have access to a primary care provider (PCP). Given that almost three-quarters of Texas counties are designated as health professional shortage areas (HPSAs)[17] and nearly a quarter of Texans are uninsured, some patients may not have another option.
- A patient may have a regular PCP, but the provider does not offer any after-hour services.
- A patient may have a regular PCP and access to after-hour services, but still choose to seek care at the ER because the patient believes the hospital setting provides higher quality and immediate care. With no co-payments for either the primary care provider or the ER, patients have no financial incentive to seek care in the most cost effective setting.

### *State Actions to Reduce Unnecessary Emergency Room Visits*

PCPs are typically thought of as the "gatekeepers" of the health care system and play a key role in reducing unnecessary ER visits. PCPs provide preventive care, diagnose and treat common health issues, and make referrals to specialty care when needed. PCPs can also educate their patients on appropriate use of the ER. A patient who has regular and convenient access to a primary care provider is less likely to utilize the ER unnecessarily.

Acknowledging the importance of having a central point for primary care, state efforts to reduce unnecessary ER utilization have focused on establishing a primary care provider for Medicaid clients (commonly referred to as a "medical home" or "health home").

Primary Care Case Management

Under the Primary Care Case Management (PCCM) program, providers willing to serve as a medical home for Medicaid clients receive a monthly case management fee for each client, in

addition to their reimbursement for health care services. Medicaid clients enrolled in the PCCM program also have access to a nurse helpline 24 hours a day.[18]

Frew Initiatives

In 2007, Texas settled the *Frew vs. Suehs* class action lawsuit, which alleged that the state failed to ensure that all children enrolled in Medicaid had access to preventive services guaranteed to them under the federal Early Periodic Screening Diagnosis and Treatment Act. As part of the settlement, HHSC is implementing a number of strategic initiatives to improve access to care for children in Medicaid. One of these initiatives, the Health Home Pilot Project, will help up to eight Medicaid provider organizations transform their practices into health homes so they can provide comprehensive primary care services to children and adolescents enrolled in Medicaid.[19]

Another initiative stations promotores(as) and community health workers in emergency departments with high Medicaid ER utilization rates for non-emergency conditions. For Medicaid patients seeking care at the ER for non-emergency conditions, the promotores(as) and community health care workers provide outreach and information about benefits and services available to them, help the patients identify a medical and/or dental home, link the patients to providers, and follow-up to promote the use of preventive care.[20]

***Future Opportunities to Reduce Unnecessary Emergency Room Visits***

Primary Care Workforce

To ensure that all Texans have access to primary care, the state will need to address its existing primary care workforce shortages, especially for Medicaid patients. For a detailed discussion of this issue, see Interim Charge 5.

Health Homes

To encourage additional Medicaid providers to establish a health home for each of their Medicaid and CHIP enrollees, HHSC should establish a health home initiative in which payments are based on the provider's performance on a set of measurable wellness and prevention criteria and use of best practices. Medicaid health home providers would receive a shared portion of any savings achieved by the health home.

Patient Responsibility

Even if patients have access to a primary care provider and after hours care, they may still choose to seek care in the more expensive ER setting. The Medicaid program currently does not provide an incentive for enrollees to choose the more efficient health care option because enrollees are not charged for visiting their physician's office or the ER. Without a financial incentive to choose the more efficient health care option, Medicaid patients will have no reason to choose their primary care setting. To change this behavior and ensure that Medicaid patients are receiving care in the most appropriate and efficient health care setting, HHSC should develop Medicaid copayments for unnecessary ER visits. There may be federal limitations that restrict the use of these copayments.

## Unnecessary Hospital Admissions

Potentially preventable hospitalizations occur when a patient is hospitalized for a condition that can usually be controlled through appropriate outpatient care and patient compliance with outpatient treatment (e.g., taking medication at the right time). Using in-patient discharge data from hospitals, the Department of State Health Services (DSHS) has determined the number and cost of potentially preventable hospitalizations in Texas for ten conditions identified by the Agency for Healthcare Research and Quality (AHRQ), the federal agency responsible for health care quality, cost, outcomes, and patient safety research.

As Table 1 indicates, DSHS estimates that from 2005-2008, Texas adults received nearly $25 billion in hospital charges that were potentially preventable.[21] Bacterial pneumonia and congestive heart failure made up more than half of the avoidable charges.

**Table 1. Potentially Preventable Hospitalizations in Texas (2005 - 2008)**

| Hospitalizations for Adult Residents of Texas | Number of Hospitalizations | Average Hospital Charge | Total Hospital Charges | Average $ Impact for All Adult Texas Residents |
|---|---|---|---|---|
| Bacterial Pneumonia | 216,727 | $27,277 | $5,911,741,178 | $336 |
| Dehydration | 60,225 | $16,512 | $994,426,460 | $57 |
| Urinary Tract Infection | 123,228 | $18,843 | $2,322,012,868 | $132 |
| Angina (without procedures) | 14,319 | $16,319 | $233,676,275 | $13 |
| Congestive Heart Failure | 254,611 | $27,998 | $7,128,562,258 | $405 |
| Hypertension (High Blood Pressure) | 38,054 | $18,380 | $699,414,834 | $40 |
| Asthma | 61,306 | $20,545 | $1,259,543,126 | $72 |
| Chronic Obstructive Pulmonary Disease | 109,581 | $25,203 | $2,761,769,189 | $157 |
| Diabetes Short-term Complications | 33,341 | $21,151 | $705,191,762 | $40 |
| Diabetes Long-term Complications | 84,631 | $34,506 | $2,920,646,232 | $166 |
| **TOTAL** | **996,023** | **$25,036** | **$24,936,584,181** | **$1,418** |

DSHS also analyzed where these charges were billed. As indicated by Table 2, Medicare received a majority of the charges for preventable hospitalizations.[22] A Commonwealth Fund study on avoidable hospitalizations of nursing home residents found that nationally, spending on nursing home hospitalizations increased 29 percent from 1999 to 2004. Almost a quarter of hospitalization costs were due to pneumonia, urinary tract infections, or kidney infections, and could have been avoided with appropriate prevention and treatment in the nursing home setting.[23]

Notably, under Medicaid there is currently no financial incentive for nursing home providers to reduce the number of potentially preventable hospitalizations. Although state Medicaid programs cover long-term services such as nursing home care for individuals dually-eligible for Medicaid and Medicare, Medicare pays acute hospital-related costs for these same individuals.

As a result, any savings from reduced hospitalizations are realized to Medicare, not Medicaid. Without federal policy change allowing state Medicaid programs to share in any savings from reduced hospitalizations, Medicaid providers have little financial incentive to reduce hospitalizations.

**Table 2. Billing for Potentially Preventable Hospitalizations in Texas**

| Payer | Billed Amount | Percent |
|---|---|---|
| Medicare | $16.0 billion | 64.3% |
| Private Health Insurance | $4.4 billion | 17.5% |
| Uninsured | $2.2 billion | 8.9% |
| Medicaid | $1.7 billion | 6.8% |
| Other | $600 million | 2.5% |
| **Total** | **$24.9 billion** | **100%** |

***State Actions to Reduce Unnecessary Hospitalizations***

Texas Medicaid Enhanced Care Program

In 2004, HHSC launched the Texas Medicaid Enhanced Care Program to provide disease management services to clients not in a managed care program so that they can better self-manage their chronic illnesses and avoid hospitalizations. The program serves more than 60,000 clients with at least one of the following chronic diseases:

- Diabetes
- Asthma
- Congestive heart failure
- Chronic obstructive pulmonary disease
- Coronary artery disease

Clients in the Medicaid Enhanced Care Program receive services depending on their risk level, including disease self-management education, home visits, establishment of a primary care provider, case management, and care coordination services.[24]

Nursing Facility Incentives

In the absence of federal policy changes allowing state Medicaid programs to share in Medicare savings resulting from reduced hospitalizations, states will have to create their own incentive programs encouraging nursing homes to improve efficiency and quality of care, including reduction of unnecessary hospitalizations. Last session, the Legislature directed HHSC and the Department of Aging and Disability Services (DADS) to develop a voluntary quality of care program to exchange information with nursing facilities about their performance. The program allows for incentive payments for high-performing facilities, but a specific appropriation for this purpose would need to be made. DADS has developed a plan to construct a performance measurement system and payment methodology for future incentive payments and is currently working on implementation.

### *Future Opportunities to Reduce Unnecessary Hospitalizations*

Incomplete Data

DSHS collects inpatient hospital discharge data from over 500 hospitals in Texas. However, hospitals located in counties with a population less than 35,000 and hospitals not seeking any reimbursement for providing medical services are currently exempt from discharge data reporting requirements.[25] These exemptions prevent DSHS from having truly comprehensive state data regarding hospitalizations.

Long-term Care Incentives

In addition to establishing a performance measurement system for nursing facilities as required by the Legislature last session, HHSC should also study the feasibility of expanding a pay-for-performance program to other long-term care facilities such as intermediate care facilities for individuals with mental retardation and home and community-based providers.

Healthy Rewards Account

To encourage chronically ill Medicaid enrollees to follow their prescribed treatment plans, HHSC should develop a program in which Medicaid recipients receive credits in a "healthy rewards account" based on cost savings resulting from successful management of their condition. Medicaid enrollees could use the credits to obtain enhanced health care benefits and health care products.

## Potentially Preventable Readmissions

A potentially preventable readmission (PPR) is a hospital readmission that results from the care and treatment provided during a prior admission or from a lack of post-discharge follow-up care. A recent analysis of Medicare claims data indicates that almost one-fifth of Medicare beneficiaries were re-hospitalized within 30 days of discharge. In about half of these cases, there was no visit to a physician's office during the time between discharge and readmission.

### *State Actions to Reduce Preventable Readmissions*

Last session, the Legislature directed HHSC to report to hospitals on their performance in reducing PPRs among Medicaid patients. This feedback is intended to help providers identify areas for improvement. Hospitals are required to share these reports with providers within the hospital. In preparing the format of the report, HHSC met with the Texas Hospital Association to ensure that data reported back to hospitals was useful.

### *Future Opportunities to Reduce Preventable Readmissions*

PPR Reimbursement

Once hospitals have had an adequate amount of time to receive PPR performance feedback and an opportunity to improve practices, HHSC should develop and implement a methodology, using outcome and process measures, to adjust Medicaid reimbursement for PPRs.

Public Reporting of PPRs

To increase consumer access to health care quality information, policymakers should require the DSHS to publicly report data on hospital PPR performance. For purposes of public reporting, it

would make sense for consumers to have access to PPR data across all payers, not only Medicaid. DSHS already collects hospital discharge data across all payers, which will be necessary to determine PPRs.

## Potentially Preventable Complications

Potentially preventable complication (PPC) is a broad term used to describe any harmful event or negative outcome that occurs after a patient has been admitted to a health care facility and results from the care or treatment provided at the facility rather than a natural progression of the underlying condition. PPCs can be prevented through care and treatment that are in accordance with accepted standards of care and best practices.

Over the years, a number of terms have been used to refer to certain subcategories of PPCs (e.g., serious reportable events, hospital acquired conditions, healthcare-associated infections, and preventable adverse events). Regardless of the nomenclature, PPCs result in additional treatment, extended hospital stays, and greater health care costs.

Healthcare-Associated Infections

One specific type of complication is a healthcare-associated infection (HAI), an infection acquired by a patient while receiving medical or surgical treatment. HAIs can happen in any health care setting, including hospitals, ambulatory surgical centers, and long-term care facilities like nursing homes. According to the Centers for Disease Control and Prevention (CDC), HAIs are one of the top ten leading causes of death in the country. The CDC estimates that there are approximately 1.7 million HAIs a year, resulting in 99,000 deaths.[26] Examples of HAIs include surgical site infections, catheter associated urinary infections, and central line-associated blood stream infections.

Preventable Adverse Events

When a medical intervention causes serious injury or other harm to a patient, it is referred to as a preventable adverse event (PAE). This includes any unintentional harm caused to a patient by any aspect of the health care management.[27] PAEs include several types of healthcare-associated infections, but also include events such as:

- retention of a foreign object in a patient after surgery or other procedure;
- death during or immediately after surgery of a normal, healthy patient;
- air embolism;
- stage III or IV pressure ulcers;
- infant discharged to the wrong person;
- deep vein thrombosis following a hip or total knee replacement; and
- manifestations of poor glycemic control.

### *State Actions to Reduce Preventable Complications*

HAI and PAE Reporting System

Texas' approach thus far in reducing preventable complications has focused on public reporting. In 2007, the Legislature directed DSHS to develop an HAI reporting system and required hospitals and ambulatory surgical centers to report infections to this system. Using standardized lists of preventable adverse events created by the Centers for Medicare and Medicaid (CMS) and

the National Quality Forum (NQF), the Legislature expanded the HAI reporting system to include PAEs in 2009.

As recommended by the HAI Advisory Panel, DSHS is proceeding with use of the National Healthcare Safety Network (NHSN), a secure web-based reporting system provided by the CDC at no cost to states. DSHS will need clarifying statutory changes to allow it to use the NHSN system for HAI reporting. NHSN does not support PAE reporting at this time, so DSHS will have to develop another mechanism to allow facilities to report PAEs. DSHS has also requested funding for fiscal years 2012-13 to create a reporting system for PAEs.

If statutory barriers and funding issues are addressed, DSHS anticipates that HAI and PAE reporting will begin in 2011.[28] Information collected on HAIs and PAEs will allow facilities to improve the quality of care provided and allow patients to make informed decisions about where they seek care.

Medicaid PAE Reimbursement

In 2008, CMS began prohibiting additional Medicare payments to hospitals for treating conditions that could have been prevented. This includes 10 categories of PAEs (referred to as "hospital-acquired conditions" by CMS) that were not present upon admission to the hospital. CMS also ended all Medicare payments for:

- wrong surgical procedure;
- surgical procedure on the wrong side of the body or on the wrong body part;
- surgical procedure on the wrong patient.[29]

Last session, the Legislature directed HHSC to impose the same reimbursement policies for PAEs in Medicaid as CMS did in Medicare. HHSC has implemented changes to its claims system, allowing the system to automatically audit claims and deny payment for PAEs. HHSC began processing inpatient hospital claims through the new system on September 1, 2010.[30]

***Future Opportunities to Reduce Preventable Complications***

PPC Reporting and Reimbursement

The Legislature should direct HHSC to report back to hospitals on PPC performance (as HHSC is currently doing with PPRs). Once hospitals have had adequate time to receive PPC performance feedback and an opportunity to improve practices, HHSC should develop and implement a methodology, using outcome and process measures, to adjust Medicaid reimbursement for PPCs.

Long-term Care Facility HAI Reporting

The current state HAI reporting requirement applies to hospitals and ambulatory surgical centers. However, the NHSN system DSHS plans to use for HAI reporting is also available for long-term care facilities. Texas should take advantage of this opportunity and require long-term care facilities to report as well.

Patient Identification

Hospitals typically use colored wristbands to identify patients with certain risks or special instructions (e.g., allergies, do not resuscitate); however, no standardized protocol currently exists among hospitals. The same color could mean completely different risks or instructions depending on the hospital. For health professionals working in multiple hospitals, this inconsistency has the potential to cause serious medical errors. The Legislature should direct DSHS to work with hospitals to create a standardized patient identification protocol based on patients' medical characteristics.

## Unnecessary and Duplicative Services, Diagnostic Tests, and Medications

Without coordination of care, patients may receive duplicative tests, prescriptions, and services when visiting multiple providers that are not sharing patient health information. For example, if an individual receives a particular test, and the information is not shared with a specialist, that test may be performed again unnecessarily with added cost but no added benefit to the patient. Duplicating certain diagnostic tests could even be harmful for the patient's health, lowering the quality of care.

### *State Actions to Reduce Unnecessary and Duplicative Services, Tests, and Medications*

To increase coordination of care and reduce unnecessary and duplicative procedures, tests, and prescription drugs, the state has implemented a number of strategies.

Health Information Technology

Nationally, it is estimated that each year $8.2 billion in health care spending is due to duplicative testing in hospitals, predominately because physicians did not have access to prior test results.[31] Numerous health information technology (IT) tools are available to health care providers and have the potential to vastly improve health care quality, efficiency, and safety. Specifically, the exchange of health information between providers allows each provider involved in the care of a patient to access comprehensive and timely medical information. This allows care to be better coordinated and can eliminate duplicative tests and prescribing.

For more information about state and federal initiatives relating to electronic health records and health information exchange, see Interim Charge 4.

Medicaid Managed Care

Managed care is a health care delivery model designed to provide better access to services, improve quality, and promote efficiency. Texas began implementing Medicaid managed care in 1993 and currently operates several managed care programs: STAR, STAR+PLUS, STAR Health, NorthSTAR, and Primary Care Case Management.

Several features of managed care lead to greater efficiencies. For example, managed care organizations (MCOs) monitor and evaluate the appropriateness, necessity, and effectiveness of services delivered to clients. Care is also coordinated through the client's primary care provider who provides comprehensive primary care and makes referrals to specialty care.

In light of the current state budget deficit, HHSC provided policymakers with several cost-saving exceptional items related to managed care in its Legislative Appropriations Request for fiscal years 2012-2013:[32]

**Table 3. Medicaid Managed Care Expansion**

| Exceptional Item | Estimated GR Savings (FY 2012-13) |
|---|---|
| Expansion of STAR managed care program to additional urban areas and contiguous counties of existing STAR service areas. | $34.7 million |
| Expansion of STAR+PLUS to 13 South Texas counties. | $290 million |
| Expansion of Medicaid exclusive provider organization model in non-urban counties in Texas. | $61.2 million |
| Capitate children's dental services through a Dental Management Organization or Health Maintenance Organization. | $101.6 million |
| Include in-patient hospital costs in capitation rates for STAR+PLUS. | $28.9 million |
| Capitate vendor drug costs for Medicaid and CHIP enrollees who are enrolled in managed care. | $84.1 million |

Preferred Drug List

In 2003, in response to increasing Medicaid drug expenditures, the Legislature directed HHSC to implement Preferred Drug Lists (PDL) for Medicaid and CHIP. A PDL controls spending growth by increasing the use of selected prescription drugs that are safe, clinically efficacious, and cost effective compared to other similar drugs on the market. Drugs not on the PDL are still available, but require pre-authorization.

In addition to shifting physician prescribing patterns to safe and cost-effective drugs, the PDL also decreases drug costs through the collection of supplemental rebates from drug manufacturers. In fiscal year 2009, overall PDL savings were $365.4 million, or about 17 percent of total Medicaid drug expenditures. Of note, changes made by federal health care reform will decrease state supplemental rebate revenue beginning in 2010.

### *Future Opportunities to Reduce Unnecessary and Duplicative Services, Tests, and Medications*

Acknowledging that innovative health care delivery and payment programs are being developed on the provider level, HHSC should implement a program that allows health care providers and facilities to propose health care interventions that are cost-effective and will improve the quality of health care provided to Medicaid and CHIP enrollees. HHSC should implement programs that it determines are feasible and cost-effective.

## Medicaid Fraud

Nationally, it is estimated that more than $60 billion is lost annually due to health care fraud.[33] As stewards of state taxpayer dollars, preventing Medicaid fraud has been of particular importance to Texas policymakers.

Medicaid fraud may involve a number of parties: third parties payers (e.g., private health insurance, worker's compensation) that are liable for costs paid for by Medicaid; health care

providers; Medicaid recipients who knowingly misstate or conceal information to receive benefits; or Medicaid employees, contractors, and vendors.[34]

***State Actions to Reduce Medicaid Fraud***

Office of Inspector General

In 2003, the Texas Legislature created the HHSC Office of Inspector General (OIG) to prevent and reduce waste, abuse, and fraud within the Texas health and human services (HHS) system. The OIG works closely with the health and human services agencies and with local, state, and federal law enforcement to uphold the integrity and accountability of Texas HHS programs. The OIG has an online reporting form toll-free number to receive reports of waste, abuse, or fraud.[35]

Office of the Attorney General

Created in 1979, the Office of the Attorney General Medicaid Fraud Control Unit is responsible for conducting criminal investigations and assisting in the prosecution of health care providers who engage in fraudulent activity within the Medicaid program.[36] Medicaid provider fraud may include, but is not limited to:

- billing for services never performed;
- billing for services Medicaid has already paid for;
- prescribing drugs for unapproved use; and
- profiting illegally from referrals.

***Future Opportunities to Reduce Medicaid Fraud***

Policymakers and HHSC should continue to aggressively pursue those who cheat the Texas Medicaid program. To expand on existing state fraud prevention activities, the state should create a Medicaid transparency website similar to South Carolina's Medicaid Transparency Web Tool (http://www.scdhhs.gov/Transparency.asp), which allows the public to know how tax payer dollars are spent on the state's Medicaid program.

# Section III. Conclusion

With health care costs reaching unsustainable levels, all Texans, including health care providers, patients, and payers, will have to play an active role in containing costs. Providers will need to improve the coordination of care to increase efficiency, reduce duplicative services, and prevent medical errors; patients will need to make healthy choices; and payers will find innovative ways to encourage positive behaviors.

# Section IV. Recommendations

1. **The Health and Human Services Commission should develop outcome measures that promote safe and efficient health care behaviors by health care providers and patients. Once fair and objective outcome measures are developed, the Commission should apply them to Medicaid and CHIP payment systems.**

**Unnecessary Emergency Room Visits**

2. **The Health and Human Services Commission should establish a health home initiative in which payments are based on a provider's performance on a set of measurable wellness and prevention criteria and use of best practices. Providers would be able to receive a shared portion of any savings achieved by the health home.**

3. **The Health and Human Services Commission should develop and implement Medicaid copayments for unnecessary emergency room visits.**

**Unnecessary Hospital Admissions**

4. **Existing hospital discharge reporting exemptions should be eliminated.**

5. **The Health and Human Services Commission should study the feasibility of expanding a pay-for-performance program to long-term care facilities such as intermediate care facilities for individuals with mental retardation and home and community-based providers.**

6. **The Health and Human Services Commission should develop a program in which Medicaid recipients receive credits in a "healthy rewards account" based on cost savings resulting from successful management of chronic condition(s). Medicaid enrollees could use the credits to obtain enhanced health care benefits and health care products.**

**Potentially Preventable Readmissions**

7. **The Health and Human Services Commission should develop and implement a payment methodology, using outcome and process measures, to adjust Medicaid reimbursement for potentially preventable readmissions.**

8. **The Department of Health State Services should publicly report potentially preventable readmissions performance across all payers.**

**Potentially Preventable Complications**

9. **The Health and Human Services Commission should report to hospitals on potentially preventable complications performance and develop outcome measures to adjust Medicaid reimbursement for preventable complications after hospitals have had time to improve practices.**

**Unnecessary and Duplicative Services, Diagnostic Tests, and Medications**

10. **The Health and Human Services Commission should implement a quality-based payment initiatives program with an emphasis on efficiency, use of best practices, and outcomes.**

**Medicaid Fraud**

11. **Policymakers should continue to aggressively pursue individuals who defraud the Medicaid program.**

## 12. The Health and Human Services Commission should create a Medicaid transparency website.

[1] Kaiser Family Foundation. (2010). *U.S. Health Care Costs*. Available: http://www.kaiseredu.org/Issue Modules/US-Health-Care-Costs/Background-Brief.aspx, Accessed November 18, 2010.
[2] Centers for Medicare and Medicaid Services (2010). *NHE Fact Sheet.* Available: https://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp, Accessed: November 18, 2010.
[3]Families USA. Fact Sheet. "Shortchanged by Medical Debt," Available: http://www.familiesusa.org/assets/pdfs/ medical-debt-fact-sheet.pdf page 5, Accessed: November 18, 2010.
[4] Legislative Budget Board, *Fiscal Size-Up 2010-2011*, page 147.
[5] Health and Human Services Commission, *Testimony before the House Select Committee on Federal Legislation,* p6, 21-22, (Austin, TX, April 22, 2010).
[6] *Id.* at p9.
[7] Kaiser Family Foundation, *supra* note 1.
[8] Department of State Health Services, *Chronic Disease in Texas: A Surveillance Report of Disease Indicators*, p4, Available: http://www.dshs.state.tx.us/chronic/pdf/dipbwrptchronic.pdf.
[9] Dr. Karl Eschbach, *Testimony before the Senate Committee on Health and Human Services,* (Austin, TX, February 23, 2010).
[10] *Id.*
[11] Department of State Health Services, *supra* note 8.
[12] Milstein, Arnold and Helen Darling. "Better U.S. Health Care at Lower Cost." Issues in Science and Technology. Winter 2009, p31.
[13] Kelley, Robert. "Where Can $700 Billion in Waste be Cut Annually from the U.S. Healthcare System?" Thomson Reuters, October 2009, p24.
[14] Deputy Executive Commissioner for Health Services, Health and Human Services Commission.
[15] Dr. Charles Bell, *Testimony before the Senate Committee on Health and Human Services,* p2, (Austin, TX, April 15, 2010).
[16] Weinick, Robin M., et al. "Many Emergency Department Visits Could be Managed at Urgent Care Centers and Retail Clinics." Health Affairs, September 2010, p1630-36.
[17] Dr. Ben Raimer, *Testimony before the Senate Committee on Health and Human Services (Panel 1),* p5, (Austin, TX, February 23, 2010).
[18] Health and Human Services Commission, *Texas Medicaid and CHIP in Perspective Seventh Edition*, January 2009, Chapter 5, p7.
[19] Texas Health and Human Services Commission, *Testimony before the House Committee on Public Health and Appropriations Subcommittees on Health and Human Services and General Government,* p13, (Austin, TX, May 10, 2010).
[20] Health and Human Services Commission, *Promotores(as)/Community Health Workers in Texas Health Steps Enrollment Contract.* Available: http://www.hhsc.state.tx.us/about_hhsc/BusOpp/Promotora.shtml, Accessed: November 18, 2010.
[21]Department of State Health Services. (2010). *State of Texas Potentially Preventable Hospitalizations*. Available: http://www.dshs.state.tx.us/ph/state.shtm, Accessed November 14, 2010.
[22] Mike Gilliam, Department of State Health Services, *Testimony before the House Public Health Committee,* p7, (Austin, TX, May 10, 2010).
[23]Grabowski, David C., *"The Costs and Potential Savings Associated with Nursing Home Hospitalizations,"* The Commonwealth Fund, November/December 2007, 26(6): 1753-61.
[24]Health and Human Services Commission. *Texas Medicaid Enhanced Care Program, Provider Information.* Available: http://www.hhsc.state.tx.us/medicaid/ProviderInfo/index.html, Accessed: November 17, 2010.
[25] Sylvia Cook, Department of State Health Services, *Testimony before the House Committee on Public Health and Appropriations Subcommittee on General Government and Health and Human Services,* p3, (Austin, TX, May 10, 2010).

[26] Centers for Disease Control and Prevention. (2010). *Healthcare-Associated Infections*, Available: http://www.cdc.gov/hai/, Accessed: November 14, 2010.
[27] Dr. Charles Bell, *supra* note 15 at p9.
[28]Department of State Health Services. (2010). *Healthcare-Associated Infections.* Available: http://www.dshs.state.tx.us/idcu/health/infection_control/hai/reporting/law/, Accessed: November 17, 2010.
[29] Dr. Charles Bell, *supra* note 15 at p10.
[30] *Id*. at p11.
[31] Milstein, *supra* note 12 at p34.
[32] Health and Human Services Commission, *Legislative Appropriations Request Fiscal Years 2012-2013.* Available: http://www.hhsc.state.tx.us/LAR/2012-2013/LAR.shtml , Accessed: November 17, 2010.
[33] U.S. Attorney General Eric Holder, *National Summit on Health Care Fraud*, January 28, 2010. Available: http://www.justice.gov/ag/speeches/2010/ag-speech-100128.html, Accessed: November 18, 2010.
[34] The Office of Inspector General. *Types of Waste, Abuse, and Fraud.* Available: https://oig.hhsc.state.tx.us/AboutOIG/Types.aspx, Accessed: November 18, 2010.
[35]The Office of Inspector General. *Office of Inspector General.* Available: https://oig.hhsc.state.tx.us/, Accessed: November 18, 2010.
[36]Office of the Attorney General. (2010). *Medicaid Fraud Control Unit*. Available: https://www.oag.state.tx.us/forms/mfcu/, Accessed: November 18, 2010.

Interim Charge #10: *Study current practices of the Texas Medical Board relating to the disclosure of complaints.*

# Section I. Background

## Texas Medical Board

The Texas Medical Board (TMB) is the state agency responsible for regulating the practice of medicine by physicians in Texas. TMB consists of twelve physician members and seven public members who are appointed by the Governor for a six-year term.[1]

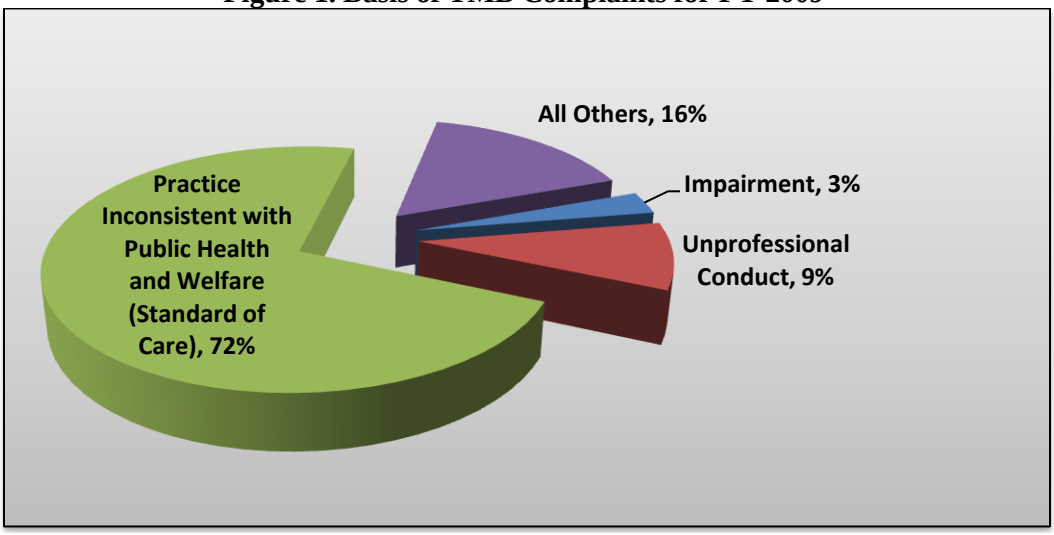
**TMB Mission**
To protect and enhance the public's health, safety, and welfare by establishing and maintaining standards of excellence used in regulating the practice of medicine and ensuring quality health care for the citizens of Texas through licensure, discipline, and education.[2]

The Texas State Board of Acupuncture Examiners and the Texas Physician Assistant Board are administratively linked to TMB but function as separate regulatory boards.[3]

## Enforcement Process

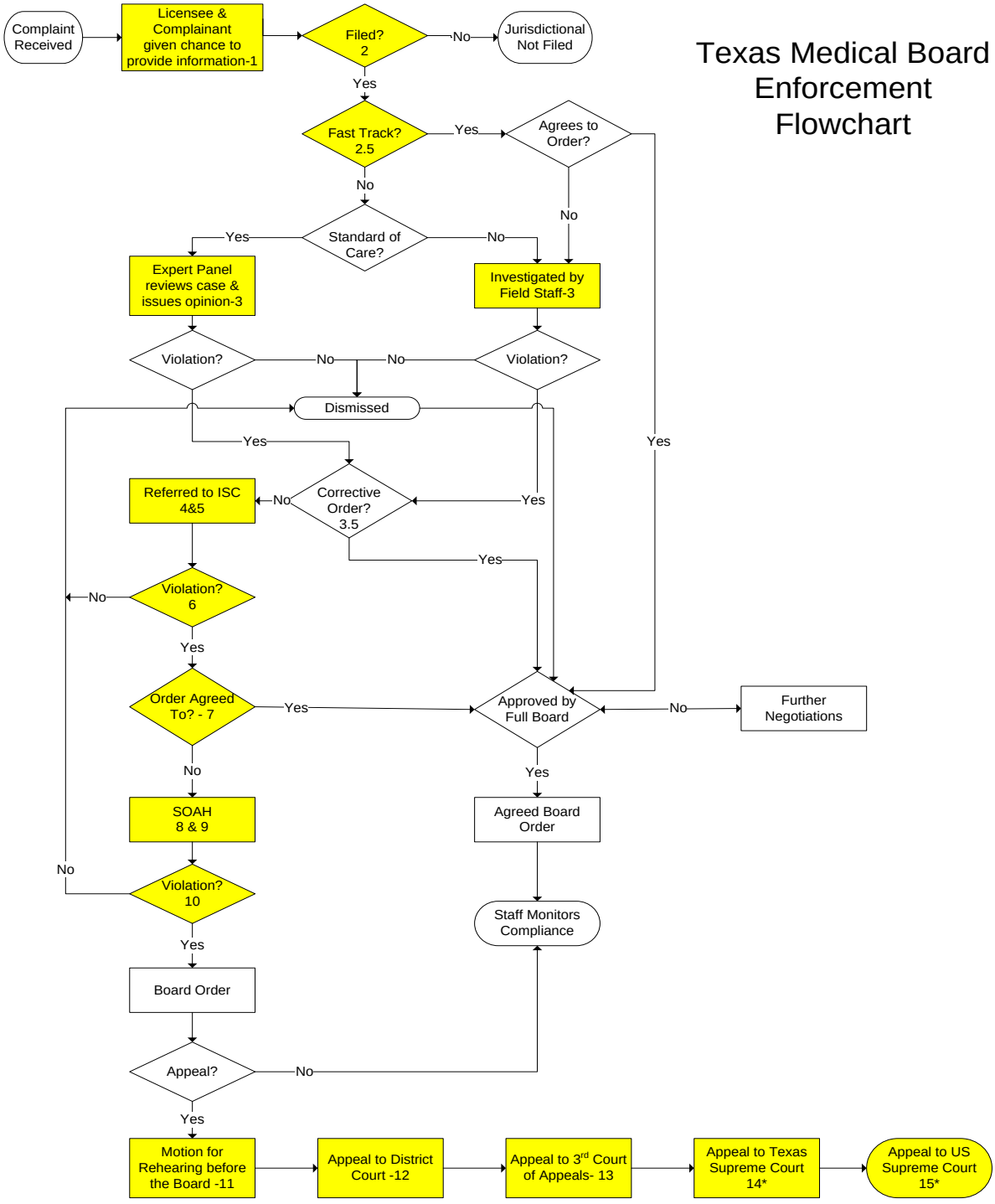
One of TMB's primary functions is to accept and investigate complaints against physicians. Once TMB receives a complaint, the agency's enforcement process begins. As Figure 1 below indicates, almost three-fourths of the complaints TMB received in fiscal year 2009 involved allegations that a physician's practice violated certain standards of care.[4]

**Figure 1. Basis of TMB Complaints for FY 2009**




The following flow chart provides an overview of TMB's enforcement process.[5] See Appendix 1 for a more detailed summary of each step.

**Figure 2. TMB Enforcement Process**




*The Texas and the US Supreme Court can deny to hear an appeal.

# Section II: Analysis

**Texas Medical Practice Act**
State law outlines several requirements related to the acceptance and disclosure of complaints made to TMB. Under the Texas Medical Practice Act, TMB must:

1. Accept complaints from all sources.[6]
2. Maintain a record of all complaints.[7]
3. Keep all information pertaining to the investigation of a complaint confidential,[8] with certain exceptions (see numbers 4 and 5).
4. Cooperate with and assist a law enforcement agency conducting a criminal investigation of a license holder by providing information relevant to the criminal investigation. Information disclosed by TMB remains confidential and may not be disclosed by the investigating agency except as necessary to further the investigation.[9]
5. On request from a legislative committee, release all information regarding a complaint against a physician to aid in a legitimate legislative inquiry. TMB may release the information only to members of the committee and may not identify the complainant or the patient.[10]

**Anonymity versus confidentiality**
Persons making complaints to TMB can choose to provide the Board with identifying information or file a complaint anonymously.

As noted above, the Texas Medical Practice Act requires all information related to the investigation of a complaint received by TMB to remain confidential, with an exception for a law enforcement agency conducting a criminal investigation of a license holder (physician) or a legislative committee conducting a legitimate legislative inquiry. If a complainant chooses to provide TMB with identifying information, it is not shared outside the agency unless the complainant signs a confidentiality waiver. If a complainant chooses to waive his/her confidentiality, the physician receives a copy of the complaint, including the complainant's name, and the complaint itself may be used as evidence against the physician. If the complainant chooses not to waive confidentiality, the physician does not receive a copy of the complaint, and the complaint may not be used as evidence against the physician. In considering any disciplinary action, TMB's disciplinary panel will only receive a copy of the complaint if the physician has also received a copy.[11] If a complainant chooses to file a complaint anonymously, the complainant's identity is not known, even to TMB.

Complaint confidentiality policies vary among the health profession licensing boards. Like TMB, the Texas State Board of Examiners of Psychologists, Texas State Board of Pharmacy, Texas State Board of Podiatric Examiners, and Texas Board of Nursing maintain the confidentiality of complaints unless the complainant signs a confidentiality waiver or testifies at the license holder's hearing. Health profession licensing boards that do not maintain the confidentiality of complaints (i.e. provide the license holder a copy of the complaint with the complainant's name) include the Texas Board of Chiropractic Examiners, the Texas State Board of Dental Examiners, the Texas Optometry Board, the Texas Funeral Service Commission, and the Texas State Board of Veterinary Medical Examiners.[12]

***Anonymity***

Annually, 1 to 3 percent of complaints received by TMB are submitted anonymously.[13] Witnesses at the May 12th hearing of the Senate Committee on Health and Human Services testified that anonymous complaints have a high potential to result in the harassment of physicians and recommended prohibiting TMB from accepting complaints without identifying information. TMB staff noted that anonymous complaints are difficult to investigate because the agency has no way to follow up with the complainant if additional information or clarification is needed.

***Confidentiality***

While there is general agreement that anonymous complaints should be prohibited, there is less agreement on whether the confidentiality of complaints should be maintained.

At its May hearing, the Senate Committee on Health and Human Services received testimony from several witnesses who support providing physicians with a copy of the complaint (including the complainant's name), eliminating complaint confidentiality. They argue that confidential complaints allow health insurance and pharmaceutical companies, competitors, and disgruntled employees to harass physicians.

Alternatively, the committee also received testimony in support of maintaining complaint confidentiality. These witnesses testified that without confidentiality, individuals may fear retaliation and choose not to file a complaint, reducing TMB's ability to protect the public. According to TMB data, a vast majority of complaints received by TMB come from patients and friends or family of patients. Table 1 categorizes all complaints made to TMB by source for fiscal years 2002 through 2009.[14] As indicated by the table, another major source of complaints is health care professionals. Among others, this group could include a nurse employed by a physician or a competitor who becomes aware of a potential standard of care issue when treating a patient for a condition caused by another physician's error.

A much smaller subset (approximately 1 percent) of complaints comes from health insurance companies.[15] Health insurance companies are in the unique position of seeing a physician's billing practices and may notice patterns of fraud. While differences in opinion on complaint confidentiality remain, individuals and groups providing testimony at the committee's hearing in May generally agreed that health insurance and pharmaceutical companies do not face the same threat of retaliation that individuals such as patients, their families and friends, and other health professionals do, and consequently do not need the same confidentiality protections when reporting a physician to TMB.

**Table 1. Texas Medical Board Complaints by Source, FY 2002-2009**

| Source | Average Percentage | Percentage Range |
|---|---|---|
| Insurance Companies | 1% | <1% to 1% |
| Law Enforcement | 2% | <1% to 4% |
| Anonymous | 2% | 1% to 3% |
| Government Agencies | 2% | 1% to 5% |
| Consumers | 3% | 2% to 3% |
| Health Professionals | 10% | 7% to 13% |
| Texas Medical Board* | 17% | 12% to 32%** |
| Friends or Family of Patient | 23% | 19% to 27% |
| Patient | 39% | 21% to 47% |

**Includes registration responses, continuing medical education audits, medical malpractice reviews, newspaper items, and board discovered violations.*

***There were an unusually high number of complaints filed by TMB in 2005 due to requirements for investigating medical malpractice violations. Excluding 2005 data, the average percentage of complaints filed by TMB is 14% and the FY 2002-2009 percentage range is 12 to 18%.*

In 2009, Texas received national attention when two nurses in Winkler County were criminally charged with the misuse of official information after filing a complaint against a physician to TMB. After finding out a complaint had been filed against him, the physician filed a harassment complaint with the Winkler County sheriff, a friend and former patient. The sheriff was able to obtain a copy of the nurses' complaint from TMB (TMB believed the sheriff was conducting a criminal investigation on the physician). Although filed anonymously, the sheriff was able to use information from the complaint to narrow his search. He then confiscated computers from the hospital and identified the nurses when he found a copy of the complaint on one of the nurse's computers. Charges against one of the nurses were eventually dropped, and a jury found the other nurse not guilty, but not before both nurses lost their jobs.[16] While rare, the Winkler County case provides an example of the type of retaliation possible when a complainant's identity is known.

**Concerns Regarding TMB's Enforcement Process**

During the Committee's May 12th hearing, a number of concerns related to TMB's enforcement process were raised.

***Initial Notice of Complaint***

When a complaint against a physician is filed with TMB, the agency sends a letter notifying the physician of the complaint and gives the physician an opportunity to respond. In response to concerns that these letters are not written clearly enough for physicians to respond, TMB made major changes last year to the way they are written, including having them written by physicians and providing additional details about the complainant's allegations. See Appendices 2 and 3 for versions of the letter before and after the changes, respectively.

***Physician Response Time***

In response to concerns that physicians do not have sufficient time to respond to the initial notice of complaint letter, Senate Bill 2397 (81st Legislature, Nelson) would have doubled the amount of time allotted for a physician to respond, from 14 days to 28 days. Although this legislation did not pass, there is continued support for an extension of physician response time.

***Adversarial Enforcement***
Some believe TMB's enforcement process is adversarial. However, current statute does not give TMB any options other than administering a public disciplinary action or dismissal when a complaint against a physician is filed. Adding an option to resolve less severe and administrative investigations with a remedial plan would give TMB a more corrective rather than punitive alternative and provide physicians with an opportunity to learn and improve their practice.

***Patient Privacy***
The committee also received concerns that patient medical records are used in TMB investigations without the patient's consent. The federal Health Insurance Portability and Accountability Act authorizes oversight agencies like TMB to obtain patient medical records for an investigation.[17] Like all other information pertaining to an investigation, patient medical records are also kept confidential, with the exceptions for law enforcement and legislative committees discussed previously.

From a public safety perspective, obtaining patient consent for every investigation could hinder TMB's ability to regulate physicians. In some cases, the patient may be aware, and even an active participant, in the violations committed by the physician. For example, a patient who is knowingly receiving controlled substances for non-therapeutic reasons would likely not want TMB to discover and stop these violations of law. This patient would not consent to the use of his/her medical records, slowing down or even preventing TMB from prosecuting the physician.

***Expert Panels***
Some believe TMB uses anonymous, incompetent expert witnesses to review cases. Every TMB case involving a standard of care issue is reviewed by at least two members of TMB's expert panel. TMB rules require these experts be in active practice in the same or similar specialty as the licensee under investigation, board certified, and have no conflicts of interest. The expert panel's opinion is used during the Informal Settlement Conference (ISC). The experts are not anonymous, but their identity is kept confidential. Without confidentiality, physicians may be hesitant to serve on these panels for fear of harassment, increasing TMB's costs to obtain experts and lengthening the amount of time it takes for TMB to resolve complaints.[18]

Although the identity of the experts is kept confidential, the qualifications of each expert serving on the panel are available to the licensee. Should the licensee disagree with the results of the ISC, the physician may appeal the decision to the State Office of Administrative Hearings (SOAH), where the identity of expert witnesses is made available to the physician.[19]

# Section III: Conclusion
TMB is responsible for protecting the public's health, safety, and welfare through the regulation of the practice of medicine. This responsibility to the public must be balanced with ensuring that the enforcement process is also fair to physicians. While differences in opinion on how to achieve this balance still exist, there is consensus on a number of ways to make the process more fair to physicians without compromising public safety.

# Section IV: Recommendations

1. **Prohibit the Texas Medical Board from accepting anonymous complaints.**

2. **Maintain confidentiality of complaints, except those made by a pharmaceutical or health insurance company or its agent (acting in his/her official capacity).**

3. **Increase the time for physicians to respond to a notice of complaint.**

4. **Establish an option for TMB to respond to complaints that is more corrective than punitive so that the process is less adversarial.**

---

[1] Texas Medical Board. (2010). *Texas Medical Board.* Retrieved July 27, 2010, from http://www.tmb.state.tx.us/boards/medbd.php.
[2]Texas Medical Board. (2010). *Texas Medical Board Mission.* Retrieved July 27, 2010, from http://www.tmb.state.tx.us/boards/mbmis.php.
[3] Texas Medical Board. (2010). *The Boards & the Agency.* Retrieved July 27, 2010, from http://www.tmb.state.tx.us/boards/boards.php.
[4] Mari Robinson, Texas Medical Board, *Testimony before the Senate Committee on Health and Human Services,* p3, (Austin, TX, May 12, 2010).
[5] Prepared by Texas Medical Board staff, May 2010.
[6] Texas Occupations Code, § 154.051. Note: the Texas Occupations Code is silent on a time limit for filing a complaint with TMB.
[7] Medical Practice Act, § 154.052, Texas Occupations Code.
[8] Medical Practice Act, § 160.006, Texas Occupations Code.
[9] Medical Practice Act, § 164.007(h), Texas Occupations Code.
[10]Medical Practice Act, §154.055, Texas Occupations Code.
[11] Mari Robinson, Texas Medical Board, *Testimony before the Senate Committee on Health and Human Services*, (Austin, TX, May 12, 2010).
[12] Senate Research Center memo, "Occupational Licensure Board Complaint Processes," January 21, 2010.
[13] Mari Robinson, *supra* note 4 at p8.
[14] *Id*.
[15] *Id*.
[16] James Willmann, Texas Nurses Association, *Testimony before the Senate Committee on Health and Human Services*, p3-8, (Austin, TX, May 12, 2010).
[17]Texas Medical Board. (2010). *Texas Medical Board Disciplinary Process.* Retrieved September 20, 2010, from http://www.tmb.state.tx.us/consumers/DisciplinaryProcess.php
[18] Information provided by the Texas Medical Board staff, May 2010.
[19] *Id.*

# Appendix 1

## Texas Medical Board – Fifteen Steps of Due Process

Step 1 – When a jurisdictional complaint is received, both the complainant and the licensee are given the opportunity to provide more information. The initial complaints that concern standard of care are evaluated by physicians, and they write an initial notice letter to the licensee. Currently this evaluation period is limited by statute to 30 days which begins the day the board receives the complaint. The licensee is given 14 of those days to make a response. TMB has worked with Sen. Nelson on statutory language that would expand this period to 45 days, thus allowing the licensee 28 days to respond. If we receive a sufficient response from the licensee to show that no violation of law occurred, the complaint is closed at this point without ever being formally filed. Over 2,000 complaints were closed this way in FY 09.

Step 2 – If the complaint is filed after the 30 day period, the licensee receives a letter informing him of this. He is given the name of an investigator, and he can send any information to that investigator.

> Step 2.5— If the investigation concerns a purely administrative issue, the licensee can opt out of this process by signing a one page document that allows them to claim "no contest" and pay an administrative penalty as set by the board. This is referred to as the Fast Track Process. If this is done, the case skips down to Step 7. If the order is accepted by the board, the matter is fully resolved once the penalty is paid.

Step 3 – The assigned investigator will send the licensee another letter, this time generally asking for specific information. Again, the licensee may provide any information he chooses. For standard of care cases, the matter must be reviewed by at least two experts board certified in the same or similar area as the licensee, and the panel will issue a report concerning the care given in the case. Any information sent by the licensee at this point is given to the expert panel to consider in their review of the case. At the conclusion of the investigation, the matter is either referred to the board disciplinary process review committee to consider dismissal or it is referred to the Quality Assurance (QA) Panel (up to 5 board representatives) for evaluation. About 65-70% of cases are referred for dismissal at this point.

> Step 3.5—There is another option for a licensee to resolve his case at this point. If a case goes to the QA Panel, a Corrective Order may be offered. This may be used in cases where the panel believes that there was a violation of the Act, but a restriction on the license of the physician is not needed to have an appropriate resolution of the issues. If the physician accepts the order, the case skips down to Step 7. If the order is accepted by the board, the matter is fully resolved once the terms of the order are completed.

Step 4 – If the investigation indicates a violation occurred, and the QA Panel believes a restriction on the license might be needed, then the matter is referred to the legal division for prosecution the case is set for an informal settlement conference (ISC), which is an informal hearing before a board disciplinary panel. Once it has been referred, the licensee is notified of this fact and given the name of the assigned attorney to whom he can send additional information. If new information is received at this point, an effort is made to have the expert panel review the new evidence and determine if it changes their opinion. If it does, the case is referred for dismissal.

Step 5 -- Once a case has been set for an ISC, the licensee is provided all of the material that the board will use at the upcoming informal hearing 30 days prior to the hearing. This is another point where the licensee may provide

more information. If new information is received at this point, an effort is made to have the expert panel review the new evidence and determine if it changes their opinion. If it does, the case is referred for dismissal. TMB has worked with Sen. Nelson on language to extend this notice period to 45 days, and require the licensees to provide responsive information 15 days before the hearing. The current deadline to provide responsive materials is 5 days, and that is generally not a sufficient amount of time to allow the expert panel to review any new information prior to the hearing.

Step 6 – An informal hearing is held to give the licensee an opportunity to show that he is in compliance with the law, and he may bring counsel or witnesses to this hearing. The board is represented by a least one physician and one public member to hear the case. These hearings generally last an hour or longer. At the conclusion of this hearing, the panel may: recommend an agreed order, recommend dismissal, recommend additional investigation be completed, refer the case directly to SOAH, or refer the matter to a temporary suspension hearing. About 30% of cases are dismissed following the informal hearing. This step may be skipped altogether by the licensee when the licensee agrees to an order without seeking a hearing, as described by steps 2.5 and 3.5.

Step 7 – If an agreed order was recommended at the informal hearing, the staff attorney drafts the terms of the order and sends it to the licensee. The licensee may attempt to mediate the terms and/or language of the order. All such offers are given to the board representatives who sat on the disciplinary panel that heard the case to consider. If agreement can be reached at this stage, the order is sent to the full board for approval.

Step 8 – If an agreed order cannot be reached, the case is filed at SOAH. This happens in about 10% of cases where the informal hearing representatives recommended an agreed order. Following this filing, the licensee generally requests and is granted another opportunity to mediate his case using the SOAH mediation system. In some cases, such as when the board believes the only appropriate resolution is revocation, mediation is not conducted. That said, under the current system, a large portion of the cases at SOAH are mediated.

Step 9 – If there is still no agreed resolution, discovery is conducted and a full trial is held at SOAH. The licensee is generally represented by counsel, and may present evidence and cross examine the board witness including any experts.

Step 10 – The SOAH Administrative Law Judge (ALJ) issues a proposal for decision (PFD) that includes findings of fact and conclusions of law. The board may only change these finding and conclusions in narrow circumstances. The penalty is fully discretionary to the board. Once the PFD is issued, a hearing is set before the board. The ALJ is invited to present the PFD, and the licensee has the opportunity to present his position regarding the PFD to the full board, as does the board staff. At the conclusion of this hearing, the board will issue a final order.

Step 11 – If the licensee disagrees with the order of the board, he can request a rehearing of his case. The board votes on this request. If granted, Step 10 is repeated. If not, the order is considered final.

Step 12 – The licensee may appeal to district court, and this appeal must be accepted by the court.

Step 13 – Following this, the licensee may appeal to the Third Court of Appeals, and this appeal must be accepted by the court.

Step 14 – Next, the licensee may appeal to the Texas Supreme Court, and this appeal may or may not be granted by the court.

Step 15 – Next, the licensee may appeal to the U.S. Supreme Court, and this appeal may or may not be granted by the court.

## Appendix 2

Texas Medical Board

Mailing Address: P.O. Box 2018 • Austin, Tx 78768-2018
Location Address: 333 Guadalupe Tower 3 Suite 610 Austin TX 78701
Phone (512) 305-7100 • Fax (512) 305-7123

, 2009

Re: File # (please refer to this number in future correspondence.)

Dear Doctor

The Texas Medical Board (TMB) has received a complaint against you. According to state law, Texas Medical Practice Act § 154.057 (a)-(b), all complaints received by the Board against a physician must be evaluated within 30 days, or the complaint is automatically filed for investigation.

As part of this process, TMB rules allow 14 days from the date of this letter for you to respond to this complaint. **Your response is due on or before /2009**. In order to meet the statutory deadline, no extension can be granted.

Within a 30-day period, the Board must determine if there is a violation of the Medical Practice Act indicated which warrants an official investigation, or if the complaint should be closed without being filed as an official investigation. Your response is important to the Board's evaluation.

These allegation(s) fall under the general statutory violation of:

164.051(a)(6) - QC PRACTICE INCONSISTENT WITH PUBLIC HEALTH AND WELFARE - QUALITY OF CARE

The complaint allegations specifically relate to:

With regard to care and treatment of patient: r for a hysterectomy and her subsequent complications

As part of your response, you are encouraged to include any records or documents you believe are relevant. If you provide a complete copy of your office records (medical and billing), please complete the enclosed Affidavit and attach it to the submitted records. The TMB is HIPAA exempt, which means you can legally provide protected health information without further patient consent.

A determination will be made after considering your response and other available evidence. If a formal investigation is warranted and the complaint is filed, you will receive a notice letter with additional information. If the complaint is not filed, you will be notified in writing within the next few weeks. The complaint and your response, if any, will become part of the agency record of this matter.

Please forward your response and documentation to mail drop MC-263 at the address listed above. If you have any questions, please contact at (512) 931-2220.

Sincerely,

The Texas Medical Board

Enclosure: Affidavit

JSUB01.doc

## Appendix 3


Texas Medical Board

Mailing Address: P.O. Box 2018 • Austin, Tx 78768-2018
Location Address: 333 Guadalupe Tower 3 Suite 610 Austin TX 78701
Phone (512) 305-7100 • Fax (512) 305-7123


2010

Re: File # . (please refer to this number in future correspondence.)

Dear Doctor

The Texas Medical Board (TMB) has received a complaint against you. According to state law, Texas Medical Practice Act § 154.057 (a)-(b), all complaints received by the Board against a physician must be evaluated within 30 days, or the complaint is automatically filed for investigation.

As part of this process, TMB rules allow 14 days from the date of this letter for you to respond to this complaint. **Your response is due on or before /2010**. In order to meet the statutory deadline, no extension can be granted.

Within a 30-day period, the Board must determine if there is a violation of the Medical Practice Act indicated which warrants an official investigation, or if the complaint should be closed without being filed as an official investigation. Your response is important to the Board's evaluation.

These allegation(s) fall under the general statutory violation of:

164.051(a)(6) - QC PRACTICE INCONSISTENT WITH PUBLIC HEALTH AND WELFARE - QUALITY OF CARE

164.052(A)(5) UNPROFESSIONAL CONDUCT

The complaint allegations specifically relate to:

In the treatment of ), it is alleged that he overmedicated the patient to such an extent that he needed immediate re-admission to a hospital upon discharge from and that he needed to be wheeled in a stretcher, as his pupils were dilated and sluggish and he could barely keep his eyes open.

. It is also alleged that he was declared stable for 3 days and discharged as the result of a request for a second opinion. This despite the fact that, that same day he allegedly was observed to have slurred speech and to be disoriented and irritable from overmedication.

As part of your response, you are encouraged to include any records or documents you believe are relevant. If you provide a complete copy of your office records (medical and billing), please complete the enclosed Affidavit and attach it to the submitted records. The TMB is HIPAA exempt, which means you can legally provide protected health information without further patient consent.

A determination will be made after considering your response and other available evidence. If a formal investigation is warranted and the complaint is filed, you will receive a notice letter with additional information. If the complaint is not filed, you will be notified in writing within the next few weeks. The complaint and your response, if any, will become part of the agency record of this matter.

The Texas Medical Board

Enclosure: Affidavit

JSUB01.doc

Interim Charge #11: *Review the types of human stem cell and human cloning research being conducted, funded, or supported by state agencies, including institutions of higher education. Make recommendations for appropriate data collection and funding protocols.*

# Section I: Background

Stem cell research is currently being conducted at universities across Texas, as evidenced by scholarly publications, testimony from university leaders and scientists, and invitations to legislators and their staff to tour university laboratories where this research is occurring.[1] Stem cell research is supported by a variety of funding sources, including federal funds, state and local funds, and funding from private for-profit and non-profit entities. Despite the multitude of research projects being pursued across the state, there is currently no mechanism in place at either the state or federal level to collect data on the type, location, and funding sources of this research.

**Types of Stem Cells**

All stem cells, regardless of the type, are useful in treating medical ailments because they have the ability to divide indefinitely and give rise to specialized types of cells. Scientists conduct research on a variety of stem cells, including:

1. **Adult Stem Cells**- Unspecialized cells found in many tissues and organs in the body that have the ability to become specialized cells in the tissue or organ in which they are found. Adult stem cells are also found in umbilical cord blood. When a tissue is damaged, adult stem cells within that organ or tissue can renew themselves to repair the damage.
2. **Embryonic Stem Cells**- Unspecialized cells derived from human embryos that can be manipulated to evolve into any type of specialized cell. Most embryonic stem cells are derived from embryos that develop from eggs that have been fertilized in an in vitro fertilization clinic and then donated for research purposes.[2]

Both adult and embryonic stem cells can be found in humans and animals, and scientists across the state use a combination of human and animal embryonic and adult stem cells in their research. However, this report focuses exclusively on collecting data on human stem cell research, both embryonic and adult. In the course of researching this interim charge, the committee found that no human cloning research is currently being conducted at state agencies or institutions.

# Section II: Analysis

In general, current knowledge of stem cell research being conducted in Texas is based on anecdotal evidence. Without comprehensive, regularly-collected data on this research, legislators do not have sufficient evidence with which to make important decisions regarding appropriations and policy. Devising a means to collect stem cell research data on a regular, systematic basis would enhance this decision-making.

## Designing a Data Collection Mechanism

Designing a tool to collect data on stem cell research necessitates determining where this research is being conducted and how those entities are funded. It is also important to assess

whether systems currently in place to collect data from these entities can be utilized in order to avoid duplication. Finally, a data collection tool must be comprehensive and easy to implement.

**Relevant Entities**

***State Agencies***

Other than institutions of higher education, the only state agency in Texas that conducts stem cell research is the Texas Cord Blood Bank (Bank), a division of the South Texas Blood and Tissue Center in San Antonio. The Bank was created in 2001 by the 77th Legislature with initial funding of $2 million.[3] The primary purpose of the Bank is to provide a storage system for donated umbilical cord blood so that it may be utilized in the future to treat a variety of diseases including leukemia, sickle cell disease, and lymphoma. The Bank works on a contract basis with hospitals across the state who collect donated cord blood from newborn infants. The cord blood is then sorted, stored, and eventually distributed for medical treatments. Although research is not its primary purpose, the Bank is engaged in limited medical research into the uses of adult stem cells found in umbilical cord blood. Adult stem cells from umbilical cord blood are often used as a less invasive and less painful alternative to bone marrow transplants. Over its nearly 10 year history, only $1 million of the total $16.5 million appropriated to the Bank has been designated for research purposes.[4]

***Public Universities***

Texas' system of public higher education institutions is governed by the Texas Higher Education Coordinating Board (THECB) and encompasses 35 general academic institutions and four university health science systems.[5] Within these four systems, a total of nine health science centers are located across Texas. With the exception of the University of North Texas Health Science Center at Fort Worth, all of these institutions have regional campuses.[6] The locations of these campuses can be found in Figures A1 through A3 in the Appendix.

The majority of human stem cell research in Texas is being conducted at the nine health science centers. Funding for research at these institutions is provided biennially through the General Appropriations Act passed by the Texas Legislature each legislative session. Specifically, the Legislative Budget Board utilizes a Research Support Formula for medical and clinical research at these institutions. This includes a base amount plus a percentage of research expenditures. For the 2010-2011 biennium, each institution was appropriated a base amount of $1,412,500, plus 1.48% of their total research expenditures, all allocated from General Revenue Funds. This resulted in a total of $72 million in General Revenue Funds being allocated across the nine institutions. Specific allocations are depicted in Figure 1. Although these are the amounts specifically designated for research, appropriations are distributed to institutions in a lump sum, so it is possible that other state funds not captured in the Research Support Formula are also used for research purposes.

Research funding for the 35 general academic institutions within Texas' public higher education system is provided through a combination of direct appropriations to the universities, grants that are funneled through the THECB, and contracts with state or local government agencies. Research appropriations are made through the following channels:

1. **The Research Development Fund** is used to finance research expenditures at a level of $40 million per year across all 35 general academic institutions. Appropriations from this fund may only be used to support and maintain research and student services that promote increased research capacity at the institution.[7]
2. **The Instructions and Operations Formula** is used to allocate General Revenue Funds to general academic institutions for a variety of purposes, including research enhancement. Funds are distributed based on a weighted semester credit-hour basis, with different areas of instruction receiving more funding than others based on these assigned weights. For example, in the 2010-11 biennium, instruction in Technology was weighted 2.36 per semester credit-hour, while instruction in Library Sciences was weighted 1.09 per semester.[8]
3. **The Texas Competitive Knowledge Fund** supports outstanding faculty for the purposes of instructional excellence and research. In the 2010-11 biennium, the University of Texas at Austin, Texas A&M University, the University of Houston, and Texas Tech University all received funding for a total of $126 million.[9]

Funding for research grants is typically appropriated to the THECB for specific purposes, such as advancing research in a particular area of study. After these funds are appropriated to the THECB, distribution to individual institutions is determined through a Request for Proposal (RFP) process, unless it is specified in the underlying legislation creating these grant programs that certain formulas or other guidelines for distribution must be followed. Funding for contracts is typically awarded to universities from a state agency or local government to conduct a specific research project. For example, the Texas Department of State Health Services (DSHS) may enter into a contract for the University of Texas at Austin to evaluate a state program operated by the agency.

**Figure 1. Research Formula Funding for Public Health Science Centers, General Appropriations Act 2010-2011 (General Revenue Funds)**[10]

| | |
|---|---|
| Texas Tech University Health Sciences Center | $ 13,824,115 |
| UNT Health Science Center at Ft. Worth | $ 7,373,454 |
| Texas A&M University System Health Science Center | $ 8,671,364 |
| UT Health Science Center at Tyler | $ 8,415,550 |
| UT M.D. Anderson Cancer Center | $ 17,308,289 |
| UT Health Science Center at San Antonio | $ 3,231,132 |
| UT Health Science Center at Houston | $ 5,092,450 |
| UT Medical Branch at Galveston | $ 3,770,350 |
| UT Southwestern Medical Center at Dallas | $ 3,548,730 |
| **TOTAL** | **$ 71,235,437** |

***Private Universities***

In addition to state-sponsored public institutions, private universities are also conducting human stem cell research. Although these institutions are primarily privately funded, they do receive some state funding for research through grants and contracts. As with public institutions, grant funding is typically appropriated to the THECB for a specific purpose and then distributed through a RFP process through which both public and private universities may apply for funds. Contract funds are appropriated through state agencies or local governments and distributed to universities for the completion of research projects.

The only private institution that receives a state appropriation for research is the Baylor College of Medicine (BCM), the only non-public health science center in Texas. Each biennium, the THECB is appropriated funding as a trustee of BCM and these funds are used for three separate strategies, described below.

1. **Undergraduate Medical Education:** Beginning in 1969, the Texas Legislature has directed the THECB to contract with BCM to appropriate funds for undergraduate medical education for students who are Texas residents. The funding amount is based on the average annual cost of undergraduate medical education for students at the University of Texas Medical Branch at Galveston and the University of Texas Southwestern Medical School in Dallas, the only two medical schools in existence in the state at the time that this appropriation was statutorily required.[11]
2. **Graduate Medical Education:** This funding is appropriated to all private and public medical schools in Texas based on the number of resident slots at each institution for the purpose of enhancing graduate level medical education.[12]
3. **Permanent Health Fund:** In 1999, the Texas Legislature created the Permanent Health Fund, a mutual fund for the pooled investment of endowment funds for the state's ten health-related institutions (nine of which are public). This endowment is funded by proceeds from state tobacco litigation and consists of the Permanent Health Fund for Higher Education and separate Permanent Endowment Funds for each of the health-related institutions. Appropriations from these funds must be used for medical research or patient care.[13]

The Permanent Health Fund contains a state-sponsored medical research component, and it is possible that this includes human stem cell research. Therefore, it is important that any data collection tool has the capability to capture data from private institutions that may be engaged in stem cell research. Figure 2, below, shows the breakdown of research funding sources for all institutions in Texas for Fiscal Year 2009.

**Figure 2. Sources of Funds for Research and Development, Fiscal Year 2009[14]**

| | Federal | State and Local | | Institution |
|---|---|---|---|---|
| | | Appropriated | Grants and Contracts | |
| **Public** | | | | |
| Universities | $ 860,043,863 | $261,503,662 | $126,235,023 | $208,213,023 |
| Health-Related Institutions | 857,479,035 | 261,218,276 | 30,767,451 | 134,384,761 |
| ***Total-Public*** | **1,717,522,898** | **522,721,938** | **157,002,474** | **342,597,853** |
| | | | | |
| **Private** | | | | |
| Universities | $ 79,655,411 | $ 0 | $ 1,418,982 | $ 10,007,769 |
| Health-Related Institutions | 267,130,403 | 3,734,139 | 2,462,488 | 108,511,957 |
| ***Total-Private*** | **346,785,814** | **3,734,139** | **3,881,470** | **118,519,726** |
| | | | | |
| **TOTAL** | **$2,064,308,712** | **$526,456,077** | **$160,883,944** | **$461,117,579** |

## Possible Reporting Mechanisms

### *Appropriations Process*

As mentioned above, health science centers receive state funding for research activities through the appropriations process. Prior to each legislative session, state-sponsored health science institutions must submit a Legislative Appropriations Request (LAR) to the Legislative Budget Board, which includes funding requests for a variety of strategies that the institutions deem essential to advance their goals. One of these strategies covers research expenditures. Within this request, the institutions must identify the amount being requested for various expenses related to research such as salaries and wages, capital expenditures, and other operating expenditures. Although these are the amounts specifically requested for research, institutions also have the authority to utilize funds from other strategies, so it is possible that other state funds not captured in Research Strategy portion of the LAR are also used for research purposes.[15]

Utilizing the LARs submitted as part of the appropriations process to capture data on stem cell research presents several challenges:

- The information that institutions must include in their LARs is too broad to capture all of the necessary data. Although each institution must include a brief description of proposed research in their request, they do not specify the types of research that will be conducted with the appropriated funds. Specific projects are typically determined after appropriations are made. The types of research projects funded with appropriations will depend on the goals of the university and the need for the particular research projects in question.
- There are currently no requirements that universities report to the Legislature or to the Legislative Budget Board on how state research dollars are spent after they are appropriated.
- The LAR process is limited in its scope in that only state funding is captured, excluding federal and other funds supporting stem cell research at state-sponsored institutions. Additionally, only public institutions are required to submit LARs, which excludes private institutions that are conducting stem cell research.

Due to these limitations, the appropriations process does not currently present an effective way to collect detailed data on human stem cell research and its funding sources.

***Texas Higher Education Coordinating Board***

Institutions are statutorily required to respond to an annual survey about their research expenditures conducted by the THECB.[16] Based on these surveys, the Research Expenditures Annual Report is published, which includes data from private and public general academic institutions and health science centers on all research expenditures, including overhead.[17] Institutions are asked to provide the levels of federal funds, state funds, institution-controlled funds (such as tuition), and private funds (separated into profit and non-profit). Institutions must also report spending from each of these sources by category of research. The report includes sixteen separate categories of research. In addition to these categories, health-science centers are asked to include funding sources and amounts for research in "Areas of Special Interest". Categories are listed in Figure 3.

**Figure 3. Research Expenditure Annual Report Expenditure Categories[18]**

| Research Expenditure Categories for all Institutions | Additional Research Expenditure Categories for Health-Related Institutions |
|---|---|
| • Agricultural sciences<br>• Biological and other life sciences<br>• Computer science<br>• Engineering<br>• Environmental sciences<br>• Mathematical sciences<br>• Medical sciences<br>• Physical sciences<br>• Psychology<br>• Social sciences<br>• Other sciences not classified above<br>• Arts and humanities<br>• Business administration<br>• Education<br>• Law<br>• Other non-science activities not classified above | • Aging<br>• Cancer research<br>• Cardiovascular research<br>• Child health and human development<br>• Mental health (including substance abuse) |

Due to its comprehensive nature, its inclusion of information on all funding sources, and its coverage of private and public universities, the Research Expenditures Annual Report provides a viable option for collecting data on human stem cell research and funding sources.

One possibility for utilizing the Research Expenditures Annual Report to capture this data is to simply add two categories into the survey to capture funding from different sources spent on human adult stem cell research and human embryonic stem cell research. In adding categories to the Research Expenditures Annual Report survey, the THECB should keep some considerations in mind:

- *Duplication:* Expenditures on stem cell research are likely already captured in a number of the research expenditure categories listed in Figure 3, as several of the research categories already included in the report may involve a stem cell component. Therefore, dollar amounts spent on this type of research might be counted more than once. The THECB should take this into consideration in designing the wording and placement of additional questions to avoid amounts spent on stem cell research being under or over-reported.

- *Minimally Intrusive:* Additions to the Research Expenditures Annual Report to capture stem cell research spending and funding sources should be minimally intrusive to institutions. Duplicative, onerous reporting requirements deter from the important work of researchers and their institutions. To that end, the THECB should limit changes to the Annual Research Expenditure Report to those that are absolutely necessary to capture data on stem cell research spending.

## Section III: Conclusion

In order to make informed, balanced decisions on what types of research to fund and support, it is important that Legislators have reliable and complete data on a regular basis concerning the types of stem cell research being conducted, where the research is taking place, and how it is being funded. Utilizing the channels of communication and reporting mechanisms already in use by the THECB will yield the least intrusive and most informative collection of this data.

## Section IV: Recommendations

1. **Require the Texas Higher Education Coordinating Board to include questions in the Annual Research Expenditure Report on the type and funding source of research being conducted on human stem cells.**
    a. **Collect this data from state-sponsored institutions of higher education, including health-science centers, as well as from non state-sponsored institutions that receive state funding.**
    b. **Ensure that amounts of funding are not over or under reported due to duplication.**

---

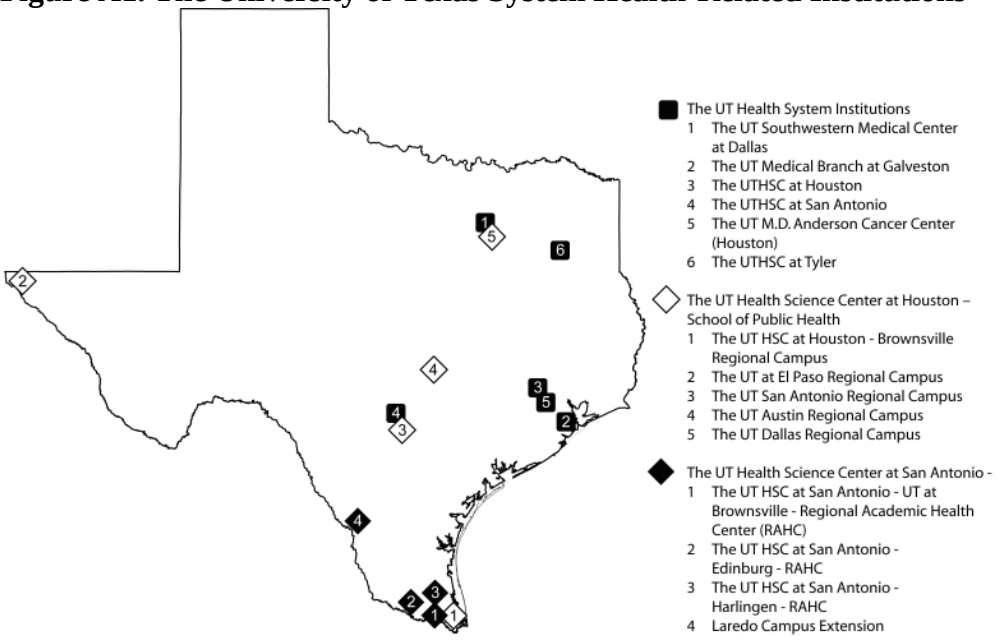
[1] Carlson, Dr. David S., Texas A&M University Health Science Center, Dr. Glenn Dillon, University of North Texas Health Science Center, Dr. Peter Davies, University of Texas Health Science Center at Houston, and Dr. Douglas M. Stocco, Texas Tech University Health Science Center, *Testimony before the Senate Committee on Health and Human Services*, (Austin, TX, March 10, 2010); Senate Committee on Health and Human Services staff has attended, by invitation, tours of the M.D. Anderson Stem Cell Research Laboratory in Houston, Texas and the Texas A&M Health Science Center College of Medicine Institute for Regenerative Medicine at Scott & White in Temple, Texas.

[2] The National Institutes of Health, "Stem Cell Information: Resources for Stem Cell Research," Available: www.stemcells.nih.gov/info/basics. Accessed: February 1, 2010.

[3] House Bill 3572, 77th Regular Session, 2001 (George/Puente/Jones);Texas General Appropriations Act, 2002-2003 biennium, Article II, Sec. 11.14.
[4] Texas General Appropriations Act, 2004-2005 biennium, Article II, Health and Human Services Commission, Item 37; Texas General Appropriations Act, 2006-2007 biennium, Article II, Sec. 14.33; Texas General Appropriations Act, 2008-2009 biennium, Article II, Health and Human Services Commission, Item 56; Texas General Appropriations Act, 2010-2011 biennium, Article II, Health and Human Services Commission, Item 58.
[5] Also included in the Texas public higher education system are three lower-division institutions, 50 community and junior college districts, one technical college system with four campuses, three dental schools, two pharmacy schools, and numerous other allied health nursing units.
[6] Texas Legislative Budget Board , "Fiscal Size-up 2010-11 Biennium," December 2009, p 261.
[7] Texas Education Code, Sec. 62.
[8] Texas General Appropriations Act, 2010-2011 biennium, Article III, Sec. 28.1.
[9] *Id*. at Sec. 53.
[10] Estrada, Daniel, Legislative Budget Board, *Testimony before the Senate Committee on Health and Human Services*, p 3, (Austin, TX, March 10, 2010).
[11] *Id*. at 245.
[12] *Id*.
[13] UTIMCO, Permanent Health Fund. Available online at: www.utimco.org/scripts/internet/fundsdetail.asp?fnd=3
[14] Texas Higher Education Coordinating Board, *Research Expenditures Annual Report*, August 2010, p 5
[15] Texas General Appropriations Act, *supra* note 8, at Sec.4.1.
[16] Texas Education Code, Section 61.051(h).
[17] Silverman, Dr. Stacey, Texas Higher Education Coordinating Board, *Testimony before the Senate Committee on Health and Human Services*, p 2, (Austin,TX, March 10, 2010).
[18] *Id*. at A-2 and A-4.

# Appendix

## Figure A1. The University of Texas System Health-Related Institutions




## Figure A2. Texas A&M University System Health-Science Centers

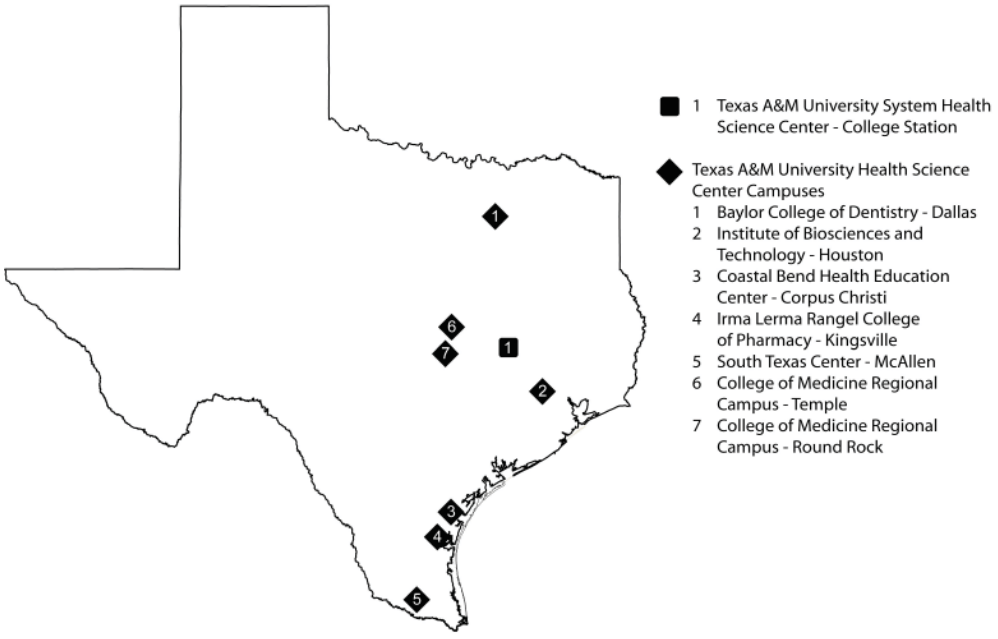
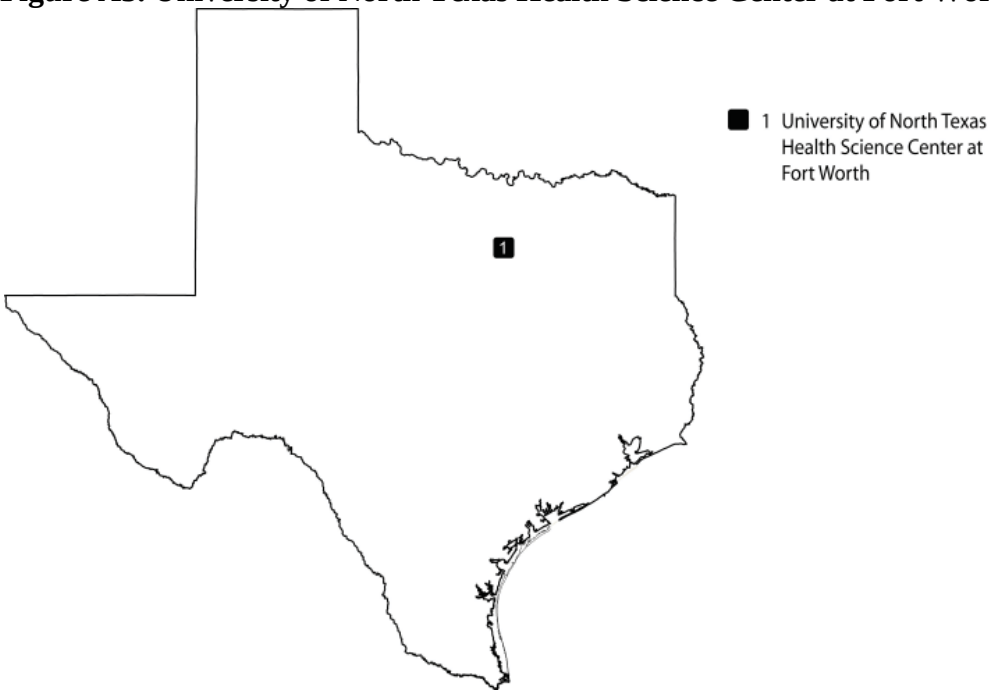


**Figure A3. University of North Texas Health Science Center at Fort Worth**




**Source:** Texas Legislative Budget Board , "Fiscal Size-up 2010-11 Biennium," December 2009, p 261-62.

Interim Charge #12: *Review the Medicaid HCBS waivers (CBA, STAR Plus, CLASS, MDCP, DBMD, TxHmL) and develop recommendations to assure that people with significant disabilities, regardless of disability label or age, receive needed services to remain in or transition to the community. Review should look at the delivery system, eligibility, service packages, rate structures, workforce issues and funding caps. Examine options for the provision of services for children aging out of the Medicaid system. Make recommendations for streamlining/combining these waivers, ensuring that these waivers are cost effective or create cost savings, and developing policies that contain costs in an effort to increase access to the services. The review should examine other states' community care waivers and provide recommendations relating to efforts that have been successful in other states.*

# Background

The Texas Medicaid program provides long term services and supports for seniors and individuals of all ages having physical, intellectual and/or developmental disabilities.[1] These long term services and supports include nursing facility services, services in an intermediate care facility for persons with mental retardation[2] (ICF/MR), and home and community based services (i.e., services provided in an individual's own home, family home, group home, foster care home or assisted living facility).[3] In fiscal year 2009, these long term services and supports comprised 22% of all Texas Medicaid services expenditures.[4]

**Medicaid Entitlement Services**

Medicaid long term services and supports include both entitlement services and waiver services. Entitlement services are services the state must provide to anyone who is eligible and seeks care. Because the Texas Medicaid Program cannot deny or delay entitlement services for individuals who satisfy Medicaid eligibility requirements, Texas cannot establish a waiting list for entitlement services. Medicaid entitlement services include both institutional services (i.e., services in a nursing home or ICF/MR) and home and community based services, including services provided in the Primary Home Care (PHC), Community Attendant Services (CAS) and Day Activity and Health Services (DAHS) programs.[5] Table 1 includes a list of Texas' Medicaid entitlement programs and a description of the target population served.

**Table 1. Texas Medicaid Entitlement Programs[6]**

| Program Feature | Nursing Facility (NF) | Primary Home Care (PHC) | Community Attendant Services (CAS) | Day Activity and Health Services (DAHS) | Hospice | Intermediate Care Facilities for MR (ICF/MR) |
|---|---|---|---|---|---|---|
| **Eligibility** | | | | | | |
| Age Served | All ages | 21+[7] | All ages | All ages[8] | All ages | All ages |
| Functional Eligibility | Requires daily skilled nursing care and must reside in a Medicaid-contracted long-term care facility for 30 consecutive days | Medical condition causes a functional limitation for at least one personal care task | Medical condition causes a functional limitation for at least one personal care task | Requires care or supervision by a licensed nurse due to functional disability related to medical diagnosis and needs assistance with one or more personal tasks | Terminal illness with fewer than six months to live | Intellectual or developmental disability or related condition[9] |
| **Services** | | | | | | |
| Description | Institutional care | Non-technical, non-medical attendant care services | Non-technical, non-medical attendant care services for individuals whose income otherwise makes them ineligible for PHC | Daytime services to individuals residing in the community[10] | Palliative care (i.e., medical, social, support services) for six months | Residential services |
| Consumer-directed Services (CDS) option available? | No | Yes | Yes | No | No | No |
| **Provider Requirements** | | | | | | |
| Licensure/certification requirements[11] | Licensed (NF) and certified | Licensed (HCSSA) and certified | Licensed (HCSSA) and certified | Licensed (HCSSA) and certified | Licensed (HCSSA) and certified | Private Providers licensed (ICF/MR) and certified; public providers certified (ICF/MR) |

**Medicaid Waiver Services**

Under federal law, states may apply for a waiver exempting them from certain Medicaid requirements. For example, a Medicaid 1915(c) Home and Community Based Services (HCBS) waiver allows states to develop waiver programs to serve individuals in their homes and communities who may otherwise receive Medicaid long term services and supports in a nursing home or ICF/MR.[12] HCBS waiver programs typically provide a broader array of services than are available in a Medicaid entitlement program.[13]

A waiver also gives states flexibility to develop programs serving specific populations (e.g., seniors, individuals with intellectual and developmental disabilities) in specific areas of the state,[14] allowing states to target where, how and to whom services are provided and to determine the type and amount of available services. Under these waiver programs, individuals may receive both traditional Medicaid services (e.g., dental services, skilled nursing services) and non medical services (e.g., respite, case management, home modifications).[15] Texas has eight Medicaid 1915(c) HCBS waiver programs. Of these, four serve individuals who may otherwise receive services in a nursing home (see Table 2) and four serve individuals who may otherwise receive services in an ICF/MR (see Table 3).[16] An individual may only be enrolled in one waiver program at a time.[17]

As provided in Table 3, a number of HCBS waiver programs offer services unique to that particular waiver program. Most notably, the Home and Community based Services (HCS) waiver program offers residential services, enabling HCS consumers to receive services in a foster care home or a 3–4 person group home. Similarly, the Community Living Assistance and Support Services (CLASS) waiver program offers an array of specialized therapies, including hippo therapy, aquatic therapy, music therapy, recreational therapy, massage therapy. No other HCBS waiver program offers residential services or specialized therapies.

**Table 2. Texas Medicaid 1915(c) HCBS Waiver Programs for Nursing Home Population[18]**

| Program Feature | STAR+PLUS | Community-Based Alternatives (CBA) | Medically Dependent Children Program (MDCP) |
|---|---|---|---|
| **Eligibility** | | | |
| Age Served | 21+ | 21+ | Children (under age 21) |
| Functional eligibility | Need for daily or regular skilled nursing | Need for daily or regular skilled nursing | Need for daily or regular skilled nursing |
| Parent(s) income considered? | No | N/A[19] | No |
| **Services** | | | |
| Examples of services common across waivers | • Direct care services (personal attendant services)<br>• Nursing<br>• Professional therapies[20]<br>• Dental<br>• Adaptive aids<br>• Minor home modifications | • Direct care services (personal attendant services)<br>• Nursing<br>• Professional therapies<br>• Dental<br>• Adaptive aids<br>• Minor home modifications | • Direct care services (respite by an attendant or licensed nurse)<br>• Adaptive aids<br>• Minor home modifications |
| Examples of services unique to a waiver | • Emergency response services<br>• Home-delivered meals<br>• Assisted living<br>• Adult foster care<br>• Transition Assistance Services | • Emergency response services<br>• Home-delivered meals<br>• Assisted living<br>• Adult foster care | • Adjunct support services |
| Case management provider | HMO service coordinator[21] | DADS staff | DADS staff |
| Consumer-directed services (CDS) options available?[22] | Yes | Yes | Yes |
| Individual annual maximum cost (i.e., funding cap) | Less than 200% of cost of comparable institutional care[23] | Less than 200% of cost of comparable institutional care[24] | 50% of cost of comparable institutional care[25] |
| **Provider Requirements** | | | |
| Licensure/certification requirements[26] | HCSSA or assisted living facility license | HCSSA or assisted living facility license | HCSSA license |
| **Interest Lists** | | | |
| Individuals on interest list[27] | 5,288[28] | 35,220 | 18,404 |
| Longest time on interest list[29] | 3-4 years | 2-3 years | 4-5 years |

**Table 3. Texas Medicaid 1915(c) HCBS Waiver Programs for ICF/MR Waiver Population[30]**

| Program Feature | Community Living Assistance and Support Services (CLASS) | Deaf-Blind Multiple Disabilities (DBMD) | Home and Community-based Services (HCS) | Texas Home Living (TxHmL) |
|---|---|---|---|---|
| **Eligibility** | | | | |
| Age Served | All ages | All ages | All ages | All ages |
| Functional eligibility | Related condition to intellectual or developmental disability with onset before age 22 | Deaf-blindness/ condition resulting in deaf-blindness before age 22 and a third disability[31] | Intellectual or developmental disability | Intellectual or developmental disability |
| Parent(s) income considered? | No | No | No | Yes |
| **Services** | | | | |
| Examples of services common across waivers | • Direct care services (habilitation)<br>• Nursing<br>• Professional therapies[32]<br>• Dental<br>• Adaptive aids<br>• Minor home modifications | • Direct care services (habilitation)<br>• Nursing<br>• Professional therapies<br>• Dental<br>• Adaptive aids<br>• Minor home modifications | • Direct care services (supported home living)<br>• Nursing<br>• Professional therapies<br>• Dental<br>• Adaptive aids<br>• Minor home modifications | • Direct care services (community support)<br>• Nursing<br>• Professional therapies<br>• Dental<br>• Adaptive aids<br>• Minor home modifications |
| Examples of services unique to a waiver | Specialized therapies<br>• Hippo therapy<br>• Aquatic therapy<br>• Music therapy<br>• Recreational therapy<br>• Massage therapy | • Intervener services<br>• Assisted living | Residential services<br>• 3- or 4-person group home<br>• Foster care home | No unique services |
| Case management provider | Private case management agency | Service provider | Mental Retardation Authority (MRA) | MRA |
| Consumer-directed services options available?[33] | Yes | Yes | Yes | Yes |
| Individual annual maximum cost (i.e., funding cap) | 200% of cost of comparable institutional care (ICF/MR)[34] | 200% of cost of comparable institutional care (ICF/MR)[35] | 200% of cost of comparable institutional care (ICF/MR)[36] | $15,000 |
| **Provider Requirements** | | | | |
| Licensure/certification requirements[37] | HCSSA license | HCSSA or assisted living facility license | Certified by DADS Regulatory Services[38] | Certified by DADS Regulatory Services[39] |
| **Interest Lists** | | | | |
| Individuals on interest list[40] | 32,650 | 316 | 45,756 | N/A (draws from HCS interest list) |
| Longest time on interest list[41] | 7–8 years | 3–4 years | 8–9 years | N/A |

Individuals may access long term services and supports through a number of resources, including DADS regional and local field offices, local Mental Retardation Authorities (MRAs), Area Agencies on Aging and Aging and Disability Resource Centers.[42] These resources are discussed in greater detail in Interim Charge #6.

# Analysis

## I. Accessing Medicaid 1915(c) Waiver Program Services

Individuals may access waiver program services in a number of ways, including interest lists, the Promoting Independence Initiative's Money Follows the Person Demonstration Project and through targeted waiver slots.

### *A. Interest Lists*

Interest lists are the most common method for individuals to enroll in a waiver program.[43] As of August 2010, almost 51,000 individuals were receiving services in a Medicaid 1915(c) waiver program and over 100,000 individuals were on a waiver program's interest list.[44] Because interest in these waiver programs often far exceeds authorized funding, a number of waiver programs have an interest list. Interest lists are operated on a first come, first served basis. Individuals registered on an interest list have expressed an interest in waiver program services. However, they have not been assessed for eligibility. An eligibility determination will occur once the individual's name reaches the top of the interest list.[45]

Although over 108,000 individuals are currently registered on an interest list, overall fewer than 32% (ranging from 10–68%, depending on the waiver) of individuals actually enroll in a waiver program once their name is released from the interest list. This may occur for a number of reasons, including the individual declining DADS' offer of waiver services (e.g., due to receiving other services or concerns about the Medicaid Estate Recovery Program[46]), failing to satisfy eligibility requirements, failing to respond or DADS being unable to locate the individual. Table 4 includes information regarding the number of individuals released from an interest list during FY 2010 and the percent enrolled in a waiver program.

**Table 4. Individuals Released From Interest Lists and Enrolled in a Waiver[47]**

| Waiver | Number Removed from Interest List | Number Enrolled | % Enrolled |
|---|---|---|---|
| **CBA** | 6,832 | 1,180 | 17.3% |
| **CLASS** | 933 | 96 | 10.3% |
| **DBMD** | 0 | 0 | 0% |
| **HCS** | 3,473 | 2,370 | 68.2% |
| **MDCP** | 522 | 106 | 20.3% |
| **Total** | **11,760** | **3,752** | **31.9%** |

Since only a fraction of individuals on an interest list ultimately enroll in a waiver program, it is impossible to accurately determine the number of individuals truly interested in, and likely eligible to receive, waiver services. To enable a better understanding of the number of individuals likely to enroll in a waiver program when their name is released from the interest list, DADS should post on its public website the historical enrollment rate for each waiver program.

Although this data only allows for future projections of need based on past enrollment patterns, other alternatives (e.g., converting to a needs based interest list) would be very costly.

Approximately 27% of individuals on an interest list receive other services (e.g., Medicaid entitlement services, services in another waiver program) while they wait, at an estimated annual cost of $75 million in General Revenue Funds ($147 million in All Funds). Table 5 provides the number of individuals on an interest list as of July 2010 who were receiving other services.

**Table 5. Individuals on an Interest List and Receiving Other Services[48]**

| Waiver Program | Individuals on Interest List | Individuals on Interest List Receiving Other Services | Percent Receiving Other Services |
|---|---|---|---|
| **CBA** | 36,111 | 22,340 | 61.9% |
| **CLASS** | 32,121 | 5,528 | 17.2% |
| **DBMD** | 312 | 108 | 34.6% |
| **HCS** | 45,884 | 8,610 | 18.8% |
| **ICM** | 2,465 | 556 | 22.6% |
| **MDCP** | 18,113 | 380 | 2.1% |
| **STAR+ PLUS** | 4,933 | 2,193 | 44.5% |
| **Total** | **139,939** | **39,715** | **28.4%** |

For the next biennium, the Health and Human Services Commission's (HHSC) FY 2012–2013 Legislative Appropriations Request includes an Exceptional Item intended to reduce or eliminate DADS' HCBS waiver programs' interest lists, at a cost of $204.2 million in General Revenue Funds ($482.3 million in All Funds) over the biennium.[49]

*B. Promoting Independence Initiative's Money Follows the Person Demonstration Project*

The Promoting Independence Initiative began in January 2000 following the U.S. Supreme Court's ruling in *Olmstead v. Zimring* requiring states to provide long term care services in the most integrated setting appropriate to the needs and wishes of individuals with disabilities.[50] The scope of this initiative is very broad, involving all the Health and Human Service agencies, the Texas Department of Housing and Community Affairs and the Texas Workforce Commission.[51]

The Money Follows the Person Demonstration Project ("Money Follows the Person") is just one element of the Promoting Independence Initiative. Beginning in 2001, Money Follows the Person is a federal enhanced funding program under which Texas receives $30 million in enhanced funding to:

- Target individuals in nursing homes with complex needs;
- Target individuals in state supported living centers (SSLCs) and certain private ICFs/MR;
- Incentivize certain private ICFs/MR to voluntarily close and convert to HCS group homes;
- Target individuals with co-occurring behavioral health needs in certain areas of the state;
- Provide post relocation support;[52] and
- Target individuals who may require an attendant during normal work hours in selected regions.

Among other projects, Money Follows the Person assists Medicaid eligible nursing home and ICF/MR residents of varying ages and disabilities who are interested in relocating to the community.[53]

1. Nursing Home Residents

Relocation specialists under contract with DADS (e.g., a Center for Independent Living or an Area Agency on Aging) are responsible for conducting outreach to Medicaid nursing home residents, providing both information and relocation services to residents interested in relocating to the community.[54] Although relocation specialists are required to verbally discuss Money Follows the Person with all residents, they focus assistance on individuals with complex service needs (e.g., lack of community housing, behavioral health issues, extensive medical needs, living in a rural area) and those who may experience extensive barriers to relocating to the community.[55] If a nursing home resident expresses interest in relocating to the community, a relocation specialist will conduct an assessment to determine the resident's needs and the feasibility of serving the resident in the community.[56] Once a resident relocates to the community, the relocation specialist must maintain contact with the individual for at least three months to ensure he/she is receiving appropriate services, serve as his/her advocate and assist with any adjustments in service needs.[57]

In most cases, Medicaid nursing home residents must reside in a nursing home for at least 90 consecutive days before being eligible to relocate to the community.[58] Eligible nursing home residents interested in relocating can access certain Medicaid 1915(c) waiver programs without being required to register their names on an interest list and wait for a waiver slot to become available. The funds previously appropriated for their care in a nursing home simply "transfer" to the waiver program in which they enroll.[59] These waiver programs include Community Based Alternatives (CBA), Community Living Assistance and Support Services (CLASS), Consolidated Waiver Program (CWP), Deaf Blind-Multiple Disabilities Program (DBMD), HCS, Medically Dependent Children Program (MDCP) and STAR+PLUS.[60] However, under Money Follows the Person, the HCS waiver program—the only waiver which includes residential services—is only available to children up to age 21. Other nursing home residents who relocate to the community live in their own homes, with family or in an assisted living setting. Of these, over 55% live with a family member, almost 20% live in an assisted living setting and almost 25% live alone in their own home.[61]

As of November 2010, 109,100 individuals resided in Texas nursing homes and 23,166, or 20% of Texas nursing home residents, expressed interest in returning to the community.[62] Since the inception of Money Follows the Person in 2001, 21,739 individuals have relocated from nursing homes into the community.[63] Based largely on Texas' success, other states have developed similar programs.

2. ICF/MR Residents

At least annually, local MRAs meet with ICF/MR residents, their families and their legally authorized representatives, if appropriate, to discuss the resident's community living options and goals and identify residents who prefer to live in the community.[64] As resources allow, individuals living in a large community ICF/MR or a SSLC who are interested in relocating and are registered on the HCS waiver program's interest list are eligible to relocate to the community

by accessing the HCS waiver program.[65] The state attempts to relocate SSLC residents to the community within 6 months and relocate residents of large community ICFs/MR to the community within one year.[66]

Since Money Follows the Person began, 3,235 ICF/MR residents have relocated to the community using targeted HCS waiver slots giving them expedited access to the HCS waiver program.[67] For the next biennium, DADS' FY 2012–2013 Legislative Appropriations Request includes an Exceptional Item intended to continue relocating individuals into the HCS waiver program, including individuals residing in large and medium ICFs/MR and individuals at imminent risk of institutionalization.[68] This Exceptional Item would require $24.5 million in General Revenue funds over the biennium.[69]

*C. Targeted HCS Waiver Slots*

In addition to accessing an HCS waiver slot through the HCS waiver program's interest list or Money Follows the Person, certain populations may bypass the HCS waiver program's interest list and immediately access an HCS waiver slot. These waiver slots are referred to as "targeted" waiver slots because they are earmarked for specific populations. Table 6 includes the number of targeted HCS waiver slots allocated for these populations and the number of individuals enrolled as of November 2010.

**Table 6. Individuals Enrolled in the HCS Waiver Program Using Targeted Waiver Slots[70]**

| Authority | Target Population | Waiver Slots Allocated | Number Enrolled |
|---|---|---|---|
| **Rider 48** | Individuals from HCS interest list | 5,120 | 2,916 |
| | Individuals leaving large private ICFs/MR | 250 | 102 |
| | Individuals leaving SSLCs | 250 | 197 |
| | Children aging out of DFPS foster care | 120 | 68 |
| | Children and adults at imminent risk of institutionalization due to emergency or crisis | 196 | 79 |
| **Rider 32** | Children under age 21 in a nursing home | 0* | 12 |
| **Rider 34** | Children from small and medium private ICFs/MR | 0* | 26 |

*Waiver slots for these populations are included in the Rider 48 5,120 waiver slot allocation.

## II. STAR+PLUS

STAR+PLUS is a Texas Medicaid managed care program that provides integrated acute care and long term services and supports[71] to certain individuals in designated areas of the state. STAR+PLUS participants select a health maintenance organization (HMO) and a primary care provider and receive all Medicaid services through the HMO. The participant's primary care provider assists with basic health care needs and can refer the participant to a specialist if additional health care is needed. If the participant has a complex medical condition, STAR+PLUS will assign the individual a service coordinator employed with the HMO and responsible for coordinating the individual's acute and long term services and supports.[72] The

HMO receives a monthly capitation payment for each participant based on an average projection of medical expenses for the typical patient.[73]

Currently, STAR+PLUS operates in four service areas. Table 7 includes additional information regarding these STAR+PLUS service areas. At any given time, approximately 165,000–170,000 individuals are enrolled in STAR+PLUS.[74]

**Table 7. STAR+PLUS Service Areas[75]**

| Service Area | Counties Served | Health Plans |
|---|---|---|
| **Bexar** | Atascosa, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson | Amerigroup, Molina, Superior |
| **Harris/Harris Expansion Area** | Brazoria, Fort Bend, Galveston, Harris, Montgomery, Waller | Amerigroup, Evercare, Molina |
| **Nueces** | Aransas, Bee, Calhoun, Jim Wells, Kleberg, Nueces, Refugio, San Patricio, Victoria | Evercare, Superior |
| **Travis** | Bastrop, Burnet, Caldwell, Hays, Lee, Travis, Williamson | Amerigroup, Evercare |

In areas where STAR+PLUS is available, certain Medicaid recipients are required to enroll whereas enrollment in STAR+PLUS for other populations is voluntary or may even be prohibited. Table 8 provides additional information regarding who qualifies for STAR+PLUS.

**Table 8. Individuals Required, Permitted and Prohibited from Enrolling in STAR+PLUS[76]**

| | |
|---|---|
| **Mandatory** | Individuals who:<br>• have a physical or mental disability and qualify for supplemental security income (SSI) benefits or for Medicaid due to low income;<br>• qualify for Community Based Alternative (CBA) waiver services;<br>• are age 21 or older and are eligible to receive Medicaid because they are in a Social Security Exclusion program and meet financial criteria for 1915(c) waiver services; and<br>• are age 21 or older and are receiving SSI |
| **Voluntary** | Children under age 21 receiving SSI |
| **Prohibited** | Individuals who:<br>• reside in a nursing home;<br>• reside in an ICF/MR;<br>• are STAR+PLUS members who have been in a nursing home for more than 120 days;<br>• are Medicaid 1915(c) waiver clients (except for CBA);<br>• are not eligible for Medicaid or for full Medicaid benefits;<br>• are children in state foster care |

*A. STAR+PLUS Expansion*

1. Dallas/Fort Worth Medicaid Managed Care Expansion Project

The 81st Legislature directed HHSC to implement the most cost effective integrated managed care model for elderly, blind and disabled clients in the Dallas and Tarrant service areas.[77] Consequently, STAR+PLUS is expected to begin operating in February 2011 in the Dallas and

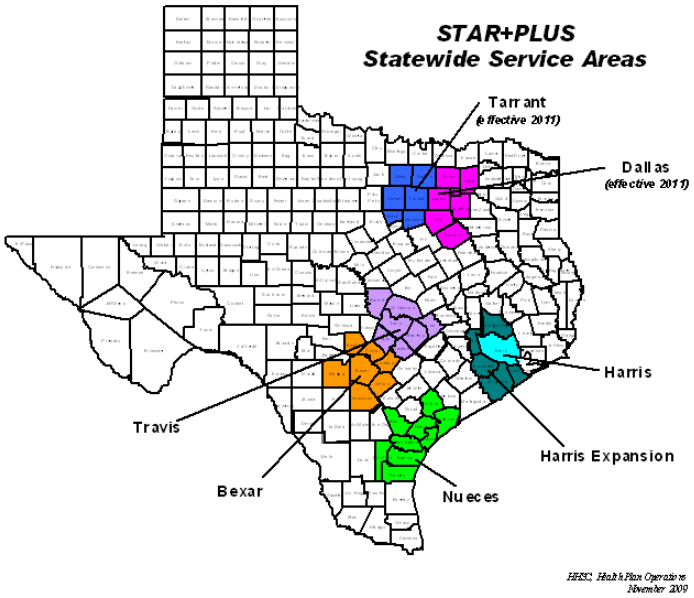
Tarrant Medicaid service areas. Table 9 includes additional information regarding the total projected STAR+PLUS population served under the Dallas/Fort Worth (DFW) expansion project.

**Table 9. STAR+PLUS DFW Expansion Areas and New Members Served**[78]

| Service Area | Counties | Population Served | Health Plans |
|---|---|---|---|
| **Dallas** | Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall | 50,591 | Molina, Superior |
| **Tarrant** | Denton, Hood, Johnson, Parker, Tarrant, Wise | 27,737 | Amerigroup, Bravo |

Figure 1 includes a map of Texas' STAR+PLUS service areas, including the 2011 expansion to the Dallas and Tarrant service areas.

**Figure 1. STAR+PLUS Service Areas**




2. Expanding Medicaid Managed Care to Certain Urban and Contiguous Counties

In addition to the DFW expansion project, HHSC plans to expand STAR+PLUS by September 2011 to certain counties contiguous to the managed care service delivery areas of Lubbock, San Antonio, Austin, Houston, Corpus Christi and El Paso, and to the urban counties of Lubbock and El Paso by March 2012.[79] HHSC's FY 2012–2013 Legislative Appropriations Request includes an Exceptional Item to implement Medicaid capitated managed care services in these areas at an estimated net savings of $34.7 million in General Revenue funds ($58.6 million in All Funds) over the biennium.[80]

3. Expanding Medicaid Managed Care in South Texas

HHSC identified South Texas as a possible STAR+PLUS expansion area, which would require a change to state law currently prohibiting the use of health maintenance organizations in Cameron, Hidalgo or Maverick counties.[81] For the next biennium, HHSC's FY 2012–2013 Legislative Appropriations Request includes an Exceptional Item to expand Medicaid managed

care in South Texas by March 2012 at an estimated net savings of $290 million in General Revenue funds ($674 million in All Funds) over the biennium.[82] Managed care services would include STAR and STAR+PLUS in 10 counties in South Texas.[83]

As STAR+PLUS rolls out to additional areas of the state, HHSC should ensure that consumer satisfaction and the quality of long term care services that contracted health plans deliver are effectively tracked and analyzed and that consumers can easily obtain comparative information regarding health plans' performance to enable them to make informed choices about which health plan to select.

## III. Increasing Access to Long Term Services and Supports

Increasing access to long term services and supports may be accomplished in a variety of ways, including more efficiently utilizing available service delivery options, increasing consumers' awareness of their long term care options and exploring new opportunities to serve individuals who may not otherwise have access to needed services.

### *A. Home and Community-based Services (HCS) Waiver Program*

The HCS waiver program permits clients to receive services in their own home, their family home or a 3–4 bed group home.[84] The 78th Legislature directed DADS (then known as the "Texas Department of Mental Health and Mental Retardation") to study and issue a report on the feasibility, costs and benefits of converting residential services in the HCS program from 3–4 bed group homes to 6 bed homes.[85] The report concluded that it would cost *less* to serve 6 individuals in an HCS home than it would to serve 3 or 4 individuals in the current 3–4 bed residential models. The report estimated that converting to a 6 bed model would save almost $7 million in General Revenue funds ($17.5 million in All Funds) per year, a savings that could allow 462 more individuals to enroll in the HCS waiver program. This report assumed providers would incur any necessary transitional costs (for relocation or renovation) and that HHSC would leave provider rates the same during the first year of implementation to assist providers with these costs. Transitional costs may include costs associated with:

- forfeiting security deposits and issuing new security deposits for leased property;
- selling and purchasing property and moving (e.g., closing costs, realtor fees, moving expenses);
- enlarging the living space of existing property; and
- modifying property to comply with certain health and safety requirements.[86]

To increase community based long term care service delivery options, DADS should require HCS providers to convert existing 3–4 bed residential models to 6 bed models and clarify the difference between a 6–bed ICF/MR and a 6–bed HCS group home (to ensure HCS providers are not required to become licensed ICF/MR providers).[87] Other states, including California, New York, Florida and Michigan, allow up to 15 bed residential models. In addition to allowing more individuals to be served in the HCS waiver program, converting existing residential models to one uniform standard would eliminate differing HCS provider enrollment criteria and fire safety requirements present in the existing 3–4 bed residential models. For example, the 3–bed model does not require 24 hour awake staff whereas the 4–bed model does.[88] In addition, the 4–bed model must meet applicable fire safety requirements (e.g., sprinkler system).[89] This conversion

would apply to all HCS group homes, as CMS does not permit grandfathering existing 3–4 bed residential providers while requiring only new providers to utilize a 6–bed model.[90]

*B. Licensed Intermediate Care Facilities for Individuals with Mental Retardation (ICFs/MR)*

Licensed ICFs/MR are community based facilities offering Medicaid entitlement services equivalent to those available in a SSLC (i.e., a state owned and operated ICF/MR). Individuals interested in enrolling in the community ICF/MR program can choose to live in any ICF/MR group home in Texas that has a vacancy appropriate to meet the individual's needs.[91] Some advocates are concerned that local MRAs—the "front doors" for individuals with intellectual and developmental disabilities needing information and assistance accessing services—may not always inform consumers of the possibility to receive services in a 6 bed ICF/MR and that consumers who do not receive this information may not otherwise know a 6 bed ICF/MR is a potential option while waiting on an interest list. To ensure that consumers are aware of all available service delivery options, DADS should ensure that local MRAs are counseling them about *all* available options, including 6 bed ICFs/MR. Under contract with DADS, local MRAs must provide a written "Explanation of Services" developed by DADS and a form describing all DADS services to anyone seeking information from the MRA. The Explanation of Services includes SSLCs and community ICF/MR providers of all sizes and is reviewed annually with consumers served by the MRA. Through its contract oversight process, DADS also reviews the MRA's activities in sharing this information with individuals seeking services and supports.

*C. Accessing Certain Community Services Through Medicaid Entitlement Programs*

Attendant care services are far less costly in the Medicaid community based entitlement programs (i.e., PHC, CAS, PCS) than in the Medicaid waiver programs (e.g., HCS, CLASS). In light of this, DADS should require waiver consumers to access attendant services through the PHC and CAS Medicaid entitlement programs (for adults) or through the PCS Medicaid entitlement program (for children). Under this structure, waiver consumers would receive attendant services through the waiver *only if* they required more hours than are currently allowed under the Medicaid entitlement programs or if they required services not available in PHC or CAS (e.g., delegated nursing services).[92] This would reduce the average waiver cost per consumer, which should enable DADS to serve more consumers.[93] For example, requiring children in the CLASS or HCS waivers to access the PCS entitlement program first would result in cost savings, considering that the hourly rate for attendant care services in PCS is $10.88–$13.04, compared to $13.85–$15.10 in CLASS and $30.20 for comparable services in HCS.[94] Under this structure, Medicaid entitlement services and waiver services would be coordinated to ensure consumers' needs are met and to prevent duplication of services.[95]

*D. Children Aging out of the Medicaid Comprehensive Care Program*

The Comprehensive Care Program is administered by HHSC and provides eligible children with a number of services, including private duty nursing services.[96] At age 21, children enrolled in the Comprehensive Care Program "age out" and are no longer eligible for private duty nursing services. Although these children may transition into a waiver program (e.g., STAR+PLUS, CBA), doing so may be difficult. In many cases, transitioning into a waiver will result in the child receiving significantly reduced levels of nursing services or a combination of nursing and attendant services (instead of purely nursing services). Alternatively, children aging out of this

program may be unable to transition into a waiver program because either they cannot be served within the waiver's cost cap (due to significant levels of private duty nursing required and no informal supports to bridge the gap)[97] or receiving fewer services may endanger their health and safety. To ensure that children aging out of the Comprehensive Care Program do not lose access to critical services, the 81st Legislature authorized DADS to use General Revenue funds for individuals who cannot safely be served in an institutional setting and whose needs exceed the waiver program's cost limits.[98] Currently, nine individuals receive pure General Revenue funded services at an annual cost of $1.1 million dollars.

HHSC and DADS are working with the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) regarding the feasibility of developing a new waiver to serve individuals with very high medical needs whose service costs would exceed existing waivers' cost caps, including individuals aging out of the Comprehensive Care Program.[99] This Hospital Level of Care waiver would be narrowly targeted to individuals whose plan of care is extended with pure General Revenue funds, thereby avoiding additional costs and the creation of a new interest list. HHSC and DADS provided CMS with preliminary information and are awaiting CMS' feedback before submitting a formal application.[100]

*E. Acquired Brain Injury Waiver*

An acquired brain injury is an injury to the brain that occurs after birth, is non-degenerative and prevents the brain's normal function .[101] An acquired brain injury may be caused by a number of factors, including external blows, jolts or penetrating wounds (known as "traumatic brain injury"); stroke; heart attack; infections producing high temperatures; brain tumors; loss of consciousness; and loss of oxygen to the brain.[102] Currently, individuals with a traumatic brain injury may receive acute care and short term post acute rehabilitation services through the Department of Assistive and Rehabilitative Services' (DARS) Comprehensive Rehabilitation Services (CRS) program, Texas' only program targeted specifically for individuals with a brain injury.[103] The CRS program does not provide long term services and supports or residential services.[104] Individuals with a brain injury who require long term services and supports may be eligible to receive services in the HCS and CLASS waivers, if they acquired the injury before age 18 or 22, respectively.[105] The CRS program is available to any Texas resident who sustains a brain injury, regardless of Medicaid status. Services are provided on a first come, first served basis and interest in the CRS program currently exceeds available funding. In FY 2010, over 600 individuals received CRS program services and almost 230 are currently on the CRS wait list.

The CRS program is funded by General Revenue and General Revenue dedicated dollars derived from traffic related fines.[106] For FY 2011, the Legislature appropriated $18.4 million to the CRS program. For the next biennium, DARS' proposed budget reduction options include a $12.5 million General Revenue reduction to the CRS program, amounting to a 70% cut. However, HHSC's FY 2012–2013 Legislative Appropriations Request includes an Exceptional Item to that would fully fund the CRS wait list.[107]

The 81st Legislature directed HHSC to conduct a feasibility study and issue a report regarding the need for a new waiver program or other long term services and supports for individuals with an acquired brain injury.[108] In September 2010, HHSC issued a report recommending a new

waiver program for individuals with an acquired brain injury.[109] The waiver would begin as a pilot serving 200 individuals, up to an annual individual cap of $15,000.[110] This pilot would allow individuals who might otherwise enter a nursing home to choose from an array of community services that best fit their needs, within the annual limit. For the next biennium, HHSC's FY 2012–2013 Legislative Appropriations Request includes an Exceptional Item to pilot an acquired brain injury waiver providing support and respite services to individuals with an acquired a brain injury.[111] Initially, 100 slots would be funded with expansion to 200 slots by FY 2015.[112] This Exceptional Item would require $1.2 million in General Revenue funds ($2.6 million in All Funds) over the biennium.[113]

## IV. Streamlining and Combining Medicaid Waiver Programs

Navigating Texas' long term services and supports system can be challenging, considering the wide variation among HCBS waivers' target populations, service arrays, rate structures, funding caps and provider requirements. To reduce confusion and eliminate any unnecessary distinctions among waivers, DADS and HHSC have initiated a number of activities to further streamline and standardize HCBS waiver programs. In addition to these efforts, streamlining certain waiver functions and consolidating waiver programs may provide additional streamlining opportunities.

### *A. DADS' Waiver Streamlining and Standardization Efforts*

In February 2008, DADS launched a waiver streamlining and standardization initiative to review waivers and recommend improvements to maximize efficiency, effectiveness and consistency among waiver programs.[114] Building on this initiative, the 81st Legislature directed DADS to streamline the administration and delivery of waiver services, possibly by reducing the number of forms used in administering the programs; revising provider manuals and training curricula; consolidating service authorization systems; eliminating unnecessary provider requirements and standardizing certain processes across waiver programs.[115] To date, DADS has initiated a number of waiver streamlining and standardization activities including:

- reducing 38 eligibility, enrollment and service authorization forms down to 11 and reviewing additional forms for possible streamlining;
- streamlining the CLASS provider handbook;
- recommending that two separate service authorization systems be consolidated into one to eliminate duplicate data and duplicate service authorization processes;
- analyzing the feasibility of standardizing the lifetime individual cost limit for minor home modifications;
- reviewing for possible standardization the policies and procedures to procure adaptive aids; and
- analyzing the feasibility of standardizing some service definitions.[116]

Notwithstanding DADS' efforts, additional opportunities exist to further streamline licensing and contracting activities associated with these waiver programs. To that end, DADS is exploring options to reduce the number of contracts needed with providers who are working with multiple DADS programs in multiple regions of the state.[117] In addition, DADS identified areas where DADS' Regulatory division's inspection results (verifying providers' compliance with license requirements) could be used by the DADS Access and Intake division when conducting contract monitoring reviews (to review providers' compliance with Medicaid contract requirements).[118] Finally, DADS recently implemented new contract monitoring protocols, streamlining the

number and frequency of monitoring reviews wherever possible.[119] This new protocol provides for a single review of a provider having multiple contracts within one region that are subject to the same rules.[120] Contract types with differing rules such as CBA and PHC are monitored with different instruments, but the monitoring is now typically accomplished during one visit to the provider.[121]

*B. HHSC's Waiver Streamlining and Standardization Efforts*

Waiver programs' rate methodologies differ according to which agency originally developed the program.[122] To make waiver rates more uniform, HHSC:

- standardized rates across all waivers administered by DADS for registered nursing, licensed vocational nursing, physical, occupational and speech therapy; behavioral support; and nutrition services;[123]
- increased TxHmL rates to parity with HCS rates for similar services;[124]
- added requisition fees to HCS and DBMD waivers to match requisition fees available in other waivers;[125] and
- expanded attendant compensation and rate enhancement to the HCS and TxHmL waiver programs, effective September 2010.[126]

In addition, HHSC proposed for the 2012–2013 biennium to standardize rates across all waivers administered by DADS for supported employment, employment assistance, respite and social work.[127] Once these standardizations are completed, the only areas where significant differences will remain in rates for waiver services will be for residential services, day habilitation, attendant compensation and administrative and overhead expenses.[128]

*C. Transferring the Case Management Function in the CLASS Waiver Program to Local MRAs*

Local MRAs provide case management[129] to individuals receiving HCS or TxHmL waiver services.[130] However, private case management agencies currently provide case management to individuals receiving CLASS waiver services. To increase consistency among the waiver programs serving individuals with intellectual and developmental disabilities, DADS could remove case management from the CLASS waiver service array and transfer this function to the local MRAs. Local MRAs already have the required expertise and MRA service coordinators' minimum qualifications are higher than CLASS program case management qualifications.[131] However, transferring the case management function to local MRAs would likely result in a loss of revenue for private CLASS case management agencies.

*D. Consolidating Waivers*

Waiver programs were developed to address the needs of specific populations, resulting in a fragmented waiver system with widely varying service arrays among the waivers. Some advocates support overhauling the current waiver system in favor of DADS developing a comprehensive HCBS waiver program serving both individuals with physical disabilities and individuals with intellectual and developmental disabilities. This comprehensive waiver would include a flexible menu of services (all services currently available in DADS' HCBS waivers) from which a consumer may select the services he/she is interested in receiving. Although CMS regulations currently prohibit DADS from serving more than one population within a single waiver program, CMS is considering issuing regulations which would allow states to do this.[132]

Assuming federal regulations eventually permit states to serve multiple populations under one consolidated waiver system, DADS would be required to reconcile the differences among existing waiver programs before pursuing a consolidated waiver, including the needs among the various populations served, financial and medical eligibility criteria, service arrays, cost limits, provider requirements, reimbursement rates and interest lists.

One of the biggest challenges in designing a comprehensive waiver system would be to control the high costs attributed to residential services now only available in the HCS waiver program and specialized therapies only available in the CLASS waiver program. Including residential services and specialized therapies in the service array would substantially increase the average costs in this waiver, which could limit the number of individuals served. To contain costs, DADS could exclude residential services and specialized therapies from the service array or DADS could place additional restrictions on consumers' eligibility for these services.[133] However, both of these cost containment strategies would substantially disrupt services for consumers who formerly received these services under the HCS and CLASS waiver programs.

## V. Increasing Efficiencies and Containing Costs

To increase efficiencies and contain costs in the HCBS waiver programs, DADS is conducting utilization management and reviews of waiver services and is rolling out a new technology designed to ensure that consumers are receiving the services for which the state is being billed. In addition to these efforts, Collectively, these measures should increase access to services by containing costs.

### *A. Utilization Review in Medicaid Home and Community Based Services Waiver Programs*

Currently, DADS conducts utilization reviews of a sample of services provided in the CBA, HCS, TxHmL, CLASS, MDCP, CWP and DBMD waiver programs to ensure quality and appropriateness of services; cost effectiveness; compliance with program policies and rules; and consumer satisfaction.[134] DADS currently uses a variety of methods to review service utilization and is in the process of revising and standardizing a number of utilization review activities across the waiver programs in order to develop more uniform utilization review processes.[135]

A recent State Auditor's Office report found that audited HCS waiver services exceeded necessary levels by 64% and that 65% of audited providers failed to comply with HCS program requirements.[136] As a result of this report, DADS plans to expand utilization reviews to *all* HCS and TxHmL waiver recipients' plans of care and level of need determinations. In addition to these efforts, DADS should develop a more comprehensive utilization review process in all Medicaid HCBS waiver programs by including targeted reviews and random sampling; prospective, concurrent and retrospective reviews as appropriate; and face to face visits with consumers.

### *B. DADS' Electronic Visit Verification Initiative*

Electronic visit verification (EVV) refers to home visit tracking systems designed to verify that service visits occur and document the time that services begin and end to ensure that consumers are receiving the authorized services for which the state is being billed.[137] This initiative may result in cost savings due to reduced timekeeping errors and fraud and benefit providers by eliminating the need for paper timesheets; streamlining payroll and billing functions; reducing

instances of fraud (overstated timesheets) and managing staff more effectively (e.g., by estimating scheduling needs, identifying lag time and training needs).[138] Using this technology, service providers will electronically document the attendant and consumer's identity, date and time services begin and end, location of service delivery and tasks the attendant performed.[139]

In response to the Legislature's directive to identify savings during the current biennium, DADS plans to launch an EVV pilot in March 2011 within one region of the state and if anticipated benefits are realized, DADS will consider implementing this technology in a wider area.[140] This initiative will impact personal attendant services, respite services and comparable services in the CBA, CLASS, CWP, DBMD and MDCP waiver programs and the PHC and CAS entitlement programs.[141] DADS may expand this initiative to other waiver programs at a later date.[142]

*C. A Tiered Waiver System*

Some states have adopted a tiered waiver system to lower waiver costs and in some cases, serve more individuals on interest lists.[143] A tiered system is a system of long term services and supports developed with different "tiers" of services, graduating from least intensity and lowest costs to greatest intensity and highest cost.[144] A tiered model may incorporate pure state funded programs, Medicaid entitlement programs and Medicaid waiver programs.[145] The tiers may share common eligibility criteria with additional criteria focusing on service need, which is used to determine the most appropriate level of service.[146] In Texas, when an individual on the HCS interest list is offered waiver services, he/she has access to the full array of services in the HCS waiver program.[147] In contrast, a tiered system may limit the choice of services, depending on which tier the individual is assigned.[148] Through use of an appropriate assessment tool, the state may be able to more accurately allocate services based on what the individual needs.[149]

*D. A Managed Care Model for Individuals with Intellectual and Developmental Disabilities*

Some states use managed care systems to contain costs in the waiver programs. The 81st Legislature directed HHSC and DADS to jointly design a plan to implement a managed care pilot to serve individuals with intellectual and developmental disabilities.[150] The Legislature authorized HHSC to contract for this study and directed the study to include input from individuals receiving services, their families, service providers, MRAs, advocacy organizations and other interested parties and to include managed care models used by other states to serve this population. In February 2010, HHSC awarded a contract to Health Management Associates (HMA) to complete the study and submit its report to HHSC. HHSC and DADS must submit a final report by December 1, 2010.[151]

## VI. Other Considerations

*A. Building Risk Management Protocols Into Medicaid HCBS Waivers*

Some disability advocates are concerned that providers often caution consumers that certain activities are simply too risky to perform without the provider's assistance, that the consumer requires a certain number of attendant hours, or the consumer cannot live alone without informal supports. These advocates support consumers being able to negotiate the terms of service delivery with the provider and receive fewer services than the provider believes are necessary, if the consumer assumes responsibility for any needs that are left unmet. In 2007, DADS developed a model form that Home and Community Support Services Agencies (HCSSAs, also referred to as "home health agencies" or "agencies") and clients may use to discuss the client's

service plan and whether the client wants to assume responsibility for certain needs or leave certain needs unmet rather than have the home health agency satisfy all the client's needs.[152] However, DADS does not require home health agencies to use this form and fewer than 10 consumers in DADS' waiver programs actually receive services based on this form.[153] Although the form documents services so that agencies will not be cited by DADS inspectors, agencies have expressed concerns about legal liability in accepting individuals with complex medical needs.[154] To increase consumers' autonomy and self direction, HHSC should consider developing risk management protocols to include in all HCBS waiver programs. These criteria should give greater effect to clients' wishes while providing home health agencies adequate protection from legal liability.

*B. DADS' Oversight of Home and Community Support Services Agencies*

Home health agencies provide services in an individual's home, including nursing; physical, occupational, or speech therapy; and personal assistance. A number of agencies provide services to both Medicare and Medicaid beneficiaries. As of November 2010, Texas had over 5,400 licensed parent and branch agencies, amounting to more than twice the number of home health agencies in any other state and almost 21% of the Medicare certified home health agencies in the nation.[155] Certain areas of Texas have experienced dramatic growth, with a majority of Texas' home health agencies located in the Houston and Dallas/Fort Worth/Arlington regions.[156]

Concerned with unjustified growth and Medicare fraud, federal regulators attempted to slow the growth of home health agencies in Texas by directing DADS to halt Medicare certifications for home health agencies, a requirement for these agencies to operate. However, DADS continues to see growth because home health agencies can circumvent DADS and obtain a Medicare certification through an accrediting agency (e.g., the Joint Commission on Accreditation of Healthcare Organizations). Once a home health agency is Medicare-certified, the agency needs only to obtain a license from DADS to operate in Texas. Currently, DADS cannot deny a license based on a finding that there is no need for a home health agency in the area. To limit home health agencies' unwarranted growth, strengthen DADS' oversight of home health agencies and enhance agency administrators' qualifications, DADS should:

- Require home health agencies to apply for a certificate of need before applying for a license;
- Require home health agency administrators to be licensed;
- Limit the number of home health agencies an administrator can oversee; and
- Require independent assessments of individuals before they begin receiving services from a home health agency.

Collectively, these measures will strengthen DADS' oversight of HCSSAs by limiting their growth to areas where there is a need, establishing a licensing program for administrators, and requiring independent assessments of home health agencies' clients.

1. <u>Certificate of Need</u>

Currently, an applicant can obtain a home health agency license if the applicant is at least 18 years old; has not been convicted of a crime that is a bar to licensure; submits a completed application and pays a licensure fee of $1,750.[157] There is no relationship between the

application for, and issuance of, a home health agency license and the size and location of the population most likely to need services from a home health agency.

Approximately 36 states currently operate some type of Certificate of Need program, law or agency for one or more healthcare sectors (e.g., hospitals, nursing homes, clinics, home health agencies).[158] Of these, 18 states have Certificate of Need laws specific to home health agencies.[159]

The bourgeoning number of home health agencies has impacted DADS' ability to timely conduct state licensing and Medicare certification inspections and complaint and incident investigations, which may jeopardize home health agency consumers' health and safety. Instituting a statewide certificate of need requirement for home health agencies would allow industry growth to be based more on the actual demand for services and divert growth to regions in which the number of seniors and individuals with disabilities is projected to increase over the next ten years. This process would also enable DADS to complete required inspections and investigations in a timelier manner, providing more protection for consumers of home health services in Texas.

2. HCSSA Administrator License

Currently, home health agency administrators are not required to be licensed.[160] At a minimum, they must have a high school diploma or general equivalency diploma (GED) and at least one year of experience or training in caring for individuals with disabilities.[161] Newly appointed HCSSA administrators are also required to receive 24 hours of training relating to home health agency administration.[162] An administrator licensure system would ensure that the administrator has the required training and qualifications to operate and manage a home health agency and would enable DADS to better ensure the safety, professionalism and proper management of a home health agency's total operation. An administrator licensure system may also alleviate poor supervision issues identified during inspections and result in decreased complaint and incident investigations.

3. Limiting the Number of HCSSAs an Administrator Oversees

Under current state regulations, home health agency administrators are responsible for directing the agency's daily operations.[163] However, in practice, one administrator may supervise and manage multiple agencies, which impacts the administrators' ability to properly direct any agency's daily operations and compromises clients' care. To ensure proper management and oversight of home health agencies, administrators should oversee no more than two licensed home health agencies.

4. Independent Assessments

In some waiver programs, home health agencies conduct initial assessments to determine clients' needs *and* provide the services, resulting in a potential conflict of interest.[164] Assessments conducted by a third party may be more objective in identifying consumer needs, without regard to profit margins or the cost of services. An independent entity contracted with HHSC or DADS could assess the individual to determine his/her medical needs and the amount and type of services needed, but would neither provide the services nor have a fiduciary relationship with the home health agency providing the services. In addition to eliminating any perceived conflict of interest, having contracted staff specialized in conducting assessments could result in a more

comprehensive service plan and reduce the number of plan changes the home health agency submits to DADS. Currently, home health agencies often do not conduct a thorough initial assessment because they cannot be assured that the consumer will be eligible for services. Once the individual is eligible, the agency will often submit numerous service plan changes, creating additional work for DADS staff.

*C. Consumer Directed Services*

Consumer Directed Services (CDS) is an option available to consumers receiving in home services in certain Medicaid entitlement and waiver programs. As an alternative to the traditional service delivery model for long term services and supports, the CDS option allows consumers to hire and manage employees who will provide their services (including setting their wages and benefits within state guidelines).[165] In many cases, these employees may be family, neighbors or friends.[166] Table 10 includes a list of Medicaid entitlement and waiver programs and services in which the CDS option is available.

**Table 10. Self Directed Services Through the CDS Option (by Program)**

| Program | Services |
|---|---|
| **CBA** | Personal assistance services; respite services; nursing; physical, occupational and speech/hearing therapy |
| **CLASS** | Habilitation services; respite services; nursing; physical, occupational and speech/hearing therapy; support consultation[167] |
| **CWP** | Personal assistance services; respite services; habilitation services; support consultation |
| **DBMD** | Residential habilitation (less than 24 hours); intervenor; respite services; support consultation |
| **HCS** | Supported home living; respite services; support consultation |
| **MDCP** | Adjunct and respite services provided by an attendant or nurse |
| **PHC, CAS** | Personal assistance services |
| **STAR+PLUS** | Personal assistance services; respite services |
| **TxHmL** | All services and support consultation |

Consumers exercising this option may hire a CDS agency to provide financial management services, including assuming payroll functions and filing federal and state employer taxes and reports on the consumer's behalf.[168] The CDS agency will help the consumer set up an initial budget and may offer guidance on recruitment, salaries, benefits and administrative costs.[169] As of August 2010, 4,568 waiver consumers use the CDS option, up from just over 2,000 consumers in February 2008.[170]

Currently, CDS agencies need only attend a three day training seminar to obtain a contract with DADS and the quality of services delivered varies across CDS agencies.[171] DADS is developing a certification process to augment current training requirements to ensure that CDS agencies have the necessary understanding of complex payroll and tax functions to assist the consumer.[172]

Some advocates believe consumers are not aware of the CDS option and support outreach activities to increase public awareness and understanding of this option. Currently, case managers (also termed "service coordinators") must inform consumers of the CDS option at the

initial service planning meeting and at least annually thereafter.[173] Case managers provide consumers with information both orally and in writing, including an overview of the CDS option, an explanation of responsibilities, benefits, risks and required minimum qualifications of service providers, and an explanation of who may be prohibited from employment under this option.[174] DADS also conducts local town hall meetings to educate individuals, family members, service providers and the general public about the CDS option.[175] In addition to these activities, DADS could increase awareness of the CDS option by conducting periodic webinars and posting webinar presentations on the department's public website.

1. Self Determination Pilot Waiver

According to CMS guidelines, *any* waiver service can be self directed.[176] The Consumer Direction Workgroup (Workgroup),[177] comprised of consumer and family members, advocates, providers and various state agencies' staff, recently issued a report with 16 recommendations, including a recommendation to create a budget neutral, cross disability,[178] self determination pilot waiver that will operate in two or more areas of the state including at least one rural and one urban site.[179] Under federal law, states are authorized to permit individuals to save or accumulate funds from their budgets for the purchase of goods and services that will increase their independence or substitute for human assistance.[180] In a self determination waiver, the consumer's budget would be based on a needs assessment and the consumer could select services that best meet his/her needs within the allotted budget amount. The Workgroup determined a pilot would be the most effective way to test new approaches that could increase self determination for individuals using DADS services beyond the CDS option.[181] The Workgroup envisioned that individuals currently in a waiver program or in the process of enrolling in a waiver program would be eligible to enroll in this pilot waiver.[182] Although the waiver would be cost neutral, DADS would require additional staff resources to write and manage the pilot and draft new rules.[183] Piloting a new waiver would also result in training and automation costs and possibly costs to develop a new assessment and allocation tool and additional staff to approve service plans and support individuals with service planning and budget allocations.

# Conclusion

Approaching a legislative session undoubtedly marked with fiscal challenges, it will be critically important that the state provide long term services and supports to vulnerable Texans in a responsible manner. Wherever possible, the state must identify efficiencies and opportunities to generate cost savings while continuing to provide needed services to children and adults with physical or intellectual disabilities. Eliminating inefficiencies and building additional safeguards into Texas' healthcare delivery system will enable the state to serve the greatest number of individuals with limited resources.

# Recommendations

1. **Direct the Health and Human Services Commission to implement Medicaid capitated managed care services in the urban counties of El Paso and Lubbock and expand Medicaid managed care in South Texas.**

2. **Direct the Department of Aging and Disability Services to require Home and Community-based Services waiver program providers to convert existing 3–4 bed residential models to 6 bed models.**

3. **Direct the Department of Aging and Disability Services to require Medicaid 1915(c) waiver program consumers to access attendant services through the Primary Home Care, Community Attendant Services or Personal Care Services Medicaid entitlement programs and access attendant services through a Medicaid waiver program only if the consumer requires services not available in the Medicaid entitlement programs or requires more service hours than are currently allowed under the Medicaid entitlement programs.**

4. **Develop a media campaign to publicize Home and Community based Services programs and the various delivery options such as self determination, consumer direction and traditional agencies.**

5. **Direct the Department of Aging and Disability Services to ensure that local Mental Retardation Authorities are counseling consumers about all available service delivery options, including 6 bed ICFs/MR.**

6. **Direct the Department of Aging and Disability Services to post on the department's public website the historical enrollment rate for each Medicaid 1915(c) Home and Community Based Services waiver program.**

7. **Direct the Department of Aging and Disability Services to develop a more comprehensive utilization management and review process in all Medicaid 1915(c) Home and Community Based Services waiver programs by including targeted reviews and random sampling; prospective, concurrent and retrospective reviews as appropriate; and face to face visits with consumers.**

8. **Direct the Health and Human Services Commission and the Department of Aging and Disability Services to jointly explore additional opportunities to further streamline licensing and contracting activities associated with Medicaid 1915(c) waiver programs.**

9. **Direct the Health and Human Services Commission to consider developing risk management protocols to include in all Medicaid 1915(c) Home and Community Based Services waiver programs.**

10. **Direct the Department of Aging and Disability Services to require home and community support services agencies to apply for a certificate of need before applying for a license.**

11. **Direct the Department of Aging and Disability Services to require home and community support services agency administrators to be licensed.**

**12. Direct the Department of Aging and Disability Services to limit the number of home and community support services agencies an administrator can oversee to no more than two licensed agencies.**

**13. Require a state entity or entity that the Health and Human Services Commission or the Department of Aging and Disability Services contracts with to conduct independent assessments of individuals before they may begin receiving services from a home and community support services agency.**

---

[1] Texas Medicaid and CHIP in Perspective, Seventh Edition, Texas Health and Human Services Commission, January 2009, Chapter 3, p. 5 (hereinafter termed "Medicaid and CHIP in Perspective"). Available online at http://www.hhsc.state.tx.us/medicaid/reports/PB7/PinkBookTOC.html (Last accessed November 13, 2010).
[2] An ICF/MR is a Medicaid entitlement program providing residential care and assistance in learning to perform daily living skills to certain individuals with intellectual and developmental disabilities. *See* Medicaid and CHIP in Perspective, Chapter 4, p. 31.
[3] Texas Health and Human Services Commission and Texas Department of Aging and Disability Services Joint Presentation to the Senate Committee on Health and Human Services, February 23, 2010, slide 1 (hereinafter termed "HHSC/DADS Senate HHS Presentation"). Available online at http://www.dads.state.tx.us/news_info/presentations/index.html (Last accessed November 13, 2010).
[4] Information provided by HHSC via email dated November 16, 2010.
[5] HHSC/DADS Senate HHS Presentation, slide 5. For a more comprehensive description of Medicaid entitlement services, see Medicaid and CHIP in Perspective, Chapter 4, pp. 28–33.
[6] Table prepared using data provided by the Department of Aging and Disability Services.
[7] HHSC provides a similar service for individuals under age 21.
[8] Individuals of all ages are eligible for DAHS services. However, individuals under age 18 are unable to attend DAHS due to licensure issues.
[9] Individual must have an IQ score of 69 or below or a diagnosis of mild to extreme deficits in adaptive behavior, and be able to participate in and benefit from active treatment (training, etc.).
[10] Services are provided Monday through Friday.
[11] Under the Consumer Directed Services option, the Consumer Directed Services Agency, a fiscal /employer agent, is not required to be licensed but must satisfy DADS' training and contracting requirements.
[12] Medicaid and CHIP in Perspective, Glossary, p. 32.
[13] *Id.* at Chapter 4, p. 33.
[14] HHSC/DADS Senate HHS Presentation, slide 7.
[15] *See* "HCBS Waivers - Section 1915 (c)," U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services. Available online at https://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp (Last accessed November 13, 2010).
[16] Table 2 excludes information regarding the Consolidated Waiver Program. SB 705 (81R; Nelson/Naishtat) discontinued this program. However, as permitted by law and to ensure no loss of federal stimulus funds, the program will operate until at least January 2011.
[17] HHSC/DADS Senate HHS Presentation, slide 8.
[18] Table prepared using data provided by the Department of Aging and Disability Services.
[19] Parental income is not considered for CBA waiver program eligibility because the waiver program does not serve children.
[20] Professional therapies include speech therapy, occupational therapy and physical therapy
[21] HMO service coordinator may be a registered nurse or licensed vocational nurse.
[22] Consumer directed services are discussed in greater detail in this report.

[23] This calculation is less than 200% of the Resource Utilization Group (RUG) for the individual, ranging from $63,160 for an individual with basic care needs to $259,822 for an individual with heavy care needs (e.g., ventilator dependency).
[24] *Id.*
[25] This calculation is 50% of the reimbursement rate that would be paid for the same individual to receive services in a nursing home, ranging from $15,790 for an individual with basic care needs to $64,955 for an individual with heavy care needs (e.g., ventilator dependency).
[26] Under the Consumer Directed Services option, the Consumer Directed Services Agency, a fiscal/employer agent, need not be licensed but must satisfy DADS training and contracting requirements.
[27] Data regarding the number of individuals on an interest list is current as of August 2010.
[28] These are non-mandatory individuals who requested CBA-like services but are not currently Medicaid eligible and are therefore not eligible to enroll in STAR+PLUS.
[29] Data regarding the longest time individuals are registered on an interest list is current as of August 2010.
[30] Table prepared by Department of Aging and Disability Services. Table excludes information regarding the Consolidated Waiver Program. SB 705 (81R/Nelson) discontinued this program. However, as permitted by law and to ensure no loss of federal stimulus funds, the program will operate until at least January 2011.
[31] A third disability may be an intellectual or developmental disability or a related condition that impairs independent functioning.
[32] Professional therapies include speech therapy, occupational therapy and physical therapy.
[33] Consumer directed services are discussed in greater detail in this report.
[34] The CLASS individual maximum dollar amount allowed for services is $114,736.
[35] The DBMD individual maximum dollar amount allowed for services is $114,736.
[36] The HCS individual maximum dollar amount ranges from $167,468–$305,877 depending on the individual's level of need.
[37]Under the Consumer Directed Services option, the Consumer Directed Services Agency, a fiscal/employer agent, need not be licensed but must satisfy DADS training and contracting requirements.
[38] HCS providers are statutorily exempt from HCSSA and assisted living facility licensure.
[39] TxHmL providers are statutorily exempt from HCSSA licensure.
[40] Data regarding the number of individuals on an interest list is current as of August 2010.
[41] Data regarding the longest time individuals are registered on an interest list is current as of August 2010.
[42] For more information, see HHSC/DADS Senate HHS Presentation, slides 4–8.
[43] HHSC/DADS Senate HHS Presentation, slide 9.
[44] Information provided by DADS via email dated November 16, 2010. *See also* "Interest Lists," Texas Department of Aging and Disability Services. Available online at http://www.dads.state.tx.us/services/interestlist/ (Last accessed November 13, 2010).
[45] HHSC/DADS Senate HHS Presentation, slide 9.
[46] For more information about Medicaid Estate Recovery, see Medicaid and CHIP in Perspective, Chapter 4, p. 38.
[47] Information provided by DADS via email dated November 16, 2010.
[48] Information provided by DADS via email dated September 7, 2010.
[49] Information provided by HHSC via email dated November 16, 2010. *See also* HHSC Joint Presentation, slide 30.
[50] "Promoting Independence," Texas Department of Aging and Disability Services. Available online at http://www.dads.state.tx.us/providers/pi/ (Last accessed November 15, 2010).
[51] Information provided by DADS via email dated July 29, 2010.
[52] Relocation specialists only work with nursing home residents, not ICF/MR residents. Information provided by DADS via email dated July 9, 2010.
[53] General Appropriations Act 2002–03 (Article II, Department of Human Services, Rider 37, 77th Legislature, SB 1, Regular Session, 2001). *See also* HB 1867 (79R).
[54] Information provided by DADS via email dated May 24, 2010 and July 9, 2010.
[55] *Id.*
[56] Information provided by DADS via email dated May 24, 2010.
[57] *Id.*
[58] Information provided by DADS via email dated November 16, 2010.

[59] Medicaid and CHIP in Perspective, Chapter 4, pp. 35–-6. This policy was codified by HB 1867 (79th Legislature, Regular Session, 2005). Prior to HB 1867, nursing facility appropriations could not be used to fund community based services.
[60] Information provided by DADS via email dated November 16, 2010. TxHmL and PACE are the only options not included in Money Follows the Person. However, no one has accessed Money Follows the Person through CWP or DBMD. In addition, because most MDCP nursing home stays are of extremely short duration, they do not qualify for the required three month stay.
[61] Information provided by DADS via email dated July 29, 2010.
[62] See "Report on persons interested in returning to the community" available online at http://www.dads.state.tx.us/providers/pi/reports/index.html (Last accessed November 13, 2010).
[63] Information provided by DADS via email dated November 16, 2010.
[64] *Id*. *See also* SB 367 (77R; Zaffirini/Naishtat) and SB 27 (80R; Nelson/Delisi). SB 367 established a community living options information process for all ICF/MR residents and SB 27 directed DADS to contract with local MRAs to implement the community living options information process and provide service coordination and relocation services to certain eligible adult residents. *See also* "Making Informed Choices: Community Living Options Information Process for Legally Authorized Representatives of Residents in State Supported Living Centers," Texas Department of Aging and Disability Services. Available online at www.dads.state.tx.us/news_info/.../DADS257-cloip-verbal.pdf (Last accessed November 15, 2010).
[65] "Promoting Independence," Texas Department of Aging and Disability Services. Available online at http://www.dads.state.tx.us/services/faqs-fact/pi.html (Last accessed November 15, 2010).
[66] "Access and Intake Services Community Options Booklet," Texas Department of Aging and Disability Services, p. 95 (hereinafter termed "DADS Access and Intake Booklet"). Available online at www.dads.state.tx.us/providers/community_options.pdf (Last accessed November 15, 2010).
[67] Information provided by DADS via email dated November 16, 2010.
[68] DADS Presentation to the Legislative Budget Board and the Governor's Office of Budget, Planning and Policy, September 16, 2010, slide 12 (hereinafter termed "DADS Joint Budget Hearing Presentation"). Available online at http://www.dads.state.tx.us/news_info/presentations/LBBGOBPP-9-16-10pdf.pdf (Last accessed November 15, 2010).
[69] Information provided by DADS via email dated November 16, 2010. This cost also includes $3.5 million for children aging out of state foster care.
[70] Information provided by DADS via email dated November 16, 2010.
[71] Long term services and supports include assistance with activities of daily living (e.g., bathing, dressing, grooming, preparing meals), home modifications and respite services.
[72] Medicaid and CHIP in Perspective, Chapter 5, pp. 9–10.
[73] *Id*. at p. 2.
[74] Information provided by HHSC via email dated November 16, 2010.
[75] HHSC/DADS Senate HHS Presentation, slide 21.
[76] "STAR+PLUS," Texas Health and Human Services Commission. Available online at http://www.hhsc.state.tx.us/starplus/Overview.htm (Last accessed November 16, 2010).
[77] Article II, Special Provisions, Section 46, SB 1, 81st Legislature.
[78] HHSC/DADS Senate HHS Presentation, slide 17. *See also* Health and Human Services Commission's Medicaid Managed Care STAR+PLUS Expansion Dallas/Tarrant Service Areas Presentation, September 2010, slide 5. Available online at http://www.hhsc.state.tx.us/medicaid/STARPLUS_DallasTarrantDocs/SPExpansionStakeholderPresentationSept_2010.pdf (Last accessed November 16, 2010).
[79] HHSC Joint Budget Presentation, slide 26.
[80] *Id* Managed care programs would include STAR and STAR+PLUS where these programs currently exist.
[81] Texas Government Code §533.0025(e).
[82] Health and Human Services Commission Presentation to the Legislative Budget Board and the Governor's Office of Budget, Planning and Policy, September 15, 2010, slides 17–18 (hereinafter termed "HHSC Joint Budget Presentation"). Available online at http://www.hhsc.state.tx.us/news/present81.asp (Last accessed November 13, 2010).
[83] HHSC Joint Budget Presentation, slide 27.
[84] The Rider 7 (76R) report led to DADS adding a 4 bed HCS group home model. Before the report, only 3 bed group homes were permitted.

[85] General Appropriations Act 2004–05 (Article II, TDMHMR, Rider 70, HB 1, 78th Legislature, Regular Session, 2003)
[86] Rider 70 Feasibility Study, Texas Department of Mental Health and Mental Retardation, August 2004, p. 9.
[87] *Id.* at p. 11.
[88] Information provided by DADS via email dated May 24, 2010.
[89] *Id.*
[90] Information provided by DADS.
[91] "Making Informed Choices: Community Living Options Information Process for Legally Authorized Representatives of Residents in State Supported Living Centers," Texas Department of Aging and Disability Services. Available online at www.dads.state.tx.us/news_info/.../DADS257-cloip-verbal.pdf (Last accessed November 15, 2010).
[92] Information provided by DADS via email dated July 9, 2010.
[93] Information provided by DADS via email dated May 24, 2010.
[94] *Id.*
[95] *Id.*
[96] HHSC/DADS Senate HHS Presentation, slide 15.
[97] *Id.*
[98] *Id.* Rider 36 authorized DADS to use general revenue funds for these individuals.
[99] HHSC/DADS Senate HHS Presentation, slide 16.
[100] *Id.*
[101] *Id.* at p. 4.
[102] *Id.*
[103] "Comprehensive Rehabilitation Services," Texas Department of Assistive and Rehabilitative Services. Available online at http://www.dars.state.tx.us/drs/crs.shtml (Last accessed November 16, 2010).
[104] Feasibility Study for Providing Community Support and Residential Services for Individuals with Acquired Brain Injury, Office of Acquired Brain Injury, Health and Human Services Commission, p. 2 (hereinafter termed "HHSC Acquired Brain Injury Study"). Available online at http://www.hhsc.state.tx.us/reports/2010/Rider66_ABIFeasibilityStudy.pdf (Last accessed November 16, 2010).
[105] Information provided by DADS via email dated May 24, 2010.
[106] HHSC Acquired Brain Injury Study, p. 16.
[107] HHSC Joint Presentation, slide 30.
[108] General Appropriations Act 2010–11 (Article II, Health and Human Services Commission, Rider 66, SB 1, 81st Legislature, Regular Session, 2009).
[109] HHSC Acquired Brain Injury Study, p. 2.
[110] *Id.*
[111] HHSC Joint Presentation, slide 31.
[112] *Id.*
[113] *Id.*
[114] HHSC/DADS Senate HHS Presentation, slide 11.
[115] SB 705 (Nelson/Naishtat). Rider 39 (81R) also required DADS to submit an annual report on the department's streamlining efforts.
[116] Information provided by DADS via email dated February 12, 2010.
[117] Information provided by DADS via email dated May 24, 2010.
[118] Information provided by DADS via email dated November 12, 2010.
[119] *Id.*
[120] *Id.*
[121] *Id.*
[122] HHSC/DADS Senate HHS Presentation, slide 13.
[123] *Id.*
[124] Information provided by HHSC via email dated May 24, 2010.
[125] *Id.*
[126] *Id.*
[127] HHSC/DADS Senate HHS Presentation, slide 13.
[128] Information provided by HHSC via email dated May 24, 2010.

[129] Case management is a process by which individuals with specific needs for services and supports are identified and a plan that efficiently utilizes health care and other resources is formulated and implemented to achieve the optimum outcome in the most cost-effective manner. *See* DADS 2010 Reference Guide, p. 136.
[130] *Id*.
[131] *Id*.
[132] *Id*.
[133] According to DADS, it is unclear whether CMS would approve rationing a service component in the menu of services available to someone otherwise eligible for waiver services. CMS assumes that when an individual is eligible for waiver services, he/she is eligible for all service components available in that waiver unless the individual's needs can be met through a non waiver resource. CMS would be more likely to approve a tiered waiver system in which DADS creates separate waivers and assigns individuals accordingly, based on their service needs. Information provided by DADS via email dated July 9, 2010.
[134] *Id*. DADS also conducts utilization review of the PHC and CAS Medicaid community based entitlement programs and plans to expand utilization review to the DAHS entitlement program.
[135] Information provided by DADS via email dated May 24, 2010.
[136] An Audit Report on The Department of Aging and Disability Services' Home and Community-based Services Program, State Auditor's Office, SAO Report No. 10-014, November 2009. Available online at http://www.sao.state.tx.us/reports/main/10-014.pdf (Last accessed November 16, 2010).
[137] "Electronic Visit Verification Initiative," Texas Department of Aging and Disability Services. Available online at http://www.dads.state.tx.us/evv/index.html (Last accessed November 14, 2010).
[138] *Id*.
[139] *Id*.
[140] *Id*.
[141] *Id*.
[142] "Frequently asked questions," Texas Department of Aging and Disability Services. Available online at http://www.dads.state.tx.us/evv/faqs.html (Last accessed November 14, 2010).
[143] Information provided by DADS via email dated May 24, 2010.
[144] *Id*.
[145] *Id*.
[146] *Id*.
[147] *Id*.
[148] *Id*.
[149] *Id*.
[150]General Appropriations Act 2010–11 (Article II, Special Provisions, Section 48, SB 1, 81st Legislature, Regular Session, 2009).
[151] Additional information about the managed care pilot is available online at http://www.hhsc.state.tx.us/ManagedCarePilot.shtml.
[152] Information provided by DADS via email dated May 24, 2010.
[153] *Id*.
[154] *Id*.
[155] Information provided by DADS via email dated October 8, 2010.
[156] *Id*.
[157] *Id*.
[158] "Certificate of Need: State Health Laws and Programs," National Conference of State Legislatures. Available online at http://www.ncsl.org/IssuesResearch/Health/CONCertificateofNeedStateLaws/tabid/14373/Default.aspx (Last accessed November 16, 2010).
[159] Information provided by DADS via email dated October 8, 2010.
[160] *Id*.
[161] *Id*.
[162] *Id*. New administrators appointed after May 2008 must receive this additional training.
[163] Information provided by DADS via email dated October 8, 2010.
[164] HCSSAs conduct assessments and provide services in the CBA, CWP, DBMD and ICM waiver programs. Local MRAs conduct assessments for individuals in the HCS and TxHmL waiver programs. Private case management agencies conduct assessments for individuals in the CLASS waiver program and DADS staff conduct assessments of individuals in the MDCP waiver program.

[165] "Consumer Directed Services (CDS)," Texas Department of Aging and Disability Services. Available online at http://www.dads.state.tx.us/providers/CDS/ (Last accessed November 14, 2010). *See also* Frequently Asked Questions (available online at the same URL). *See also* Consumer Direction Workgroup Second Biennial Report to the Texas Legislature, September 2010 (hereinafter termed "Consumer Direction Workgroup Report"). Available online at http://www.hhsc.state.tx.us/reports/2010/Consumer-Direction-Workgroup.pdf (Last accessed November 15, 2010).
[166] "FAQs," Texas Department of Aging and Disability Services. Available online at http://www.dads.state.tx.us/providers/CDS/ (Last accessed November 14, 2010). DADS is researching options to develop consistency across waiver programs regarding the family and household members who can be employees.
[167] Support consultation is an optional service a consumer may purchase to learn how to be an employer. DADS staff provide support consultation.
[168] "FAQs," Texas Department of Aging and Disability Services. Available online at http://www.dads.state.tx.us/providers/CDS/ (Last accessed November 14, 2010).
[169] *Id*.
[170] Information provided by DADS via email dated November 16, 2010. *See also* Consumer Direction Workgroup Report, p. 1.
[171] Information provided by DADS via email dated May 24, 2010.
[172] Information provided by DADS via email dated October 6, 2010.
[173] Information provided by DADS via email dated May 24, 2010.
[174] Information provided by DADS via email dated July 9, 2010.
[175]"DADS Provider News, Alerts & Bulletins viewer," Texas Department of Aging and Disability Services. Available online at http://www.dads.state.tx.us/providers/communications/alerts/alerts.cfm?alertid=343 (Last accessed November 15, 2010).
[176] Information provided by DADS via email dated July 9, 2010.
[177] SB 1586 (76R; Zaffirini/Hilderbran) established the Consumer Direction Workgroup to assist HHSC in developing and implementing the CDS option.
[178] A "cross disability" waiver would be available to individuals with any type of disability (i.e., intellectual or developmental disability, physical disability).
[179] Consumer Direction Workgroup Report, p. 2.
[180] Deficit Reduction Act of 2005 (Public Law 109-171). Information provided by DADS via email dated October 6, 2010.
[181] Information provided by DADS via email dated October 6, 2010.
[182] *Id*.
[183] *Id*.

Interim Charge #13: *Study the type, duration, frequency and effectiveness of mental health services available to and accessed by abused and neglected Texas children. Recommend strategies to address the impact of the trauma, and enhance therapeutic services available to this population in an effort to eliminate the cycle of abuse and neglect.*

# Background

In fiscal year (FY) 2009, over 68,000 Texas children were confirmed victims of abuse or neglect.[1] Circumstances were so dire in 12,107 of these cases that Child Protective Services (CPS) removed the children from their homes. Abused and neglected children are an especially vulnerable population. In many cases, they suffer profound trauma due to abuse or neglect at the hands of those closest to them. Moreover, when children are removed from their homes, they suffer the secondary trauma of being taken away from the only, albeit unsafe, home they know.

Although some physical effects of abuse or neglect may resolve with time, other effects linger for years. For example, abused and neglected children are more likely to suffer long term physical, psychological and behavioral consequences, including impaired brain development and cognitive functioning, high blood pressure, ulcers, depression, anxiety, eating disorders, suicidal behavior, teen pregnancy, poor academic performance, criminal behavior and substance abuse.[2] Abused and neglected children are also more likely to repeat the cycle of abuse and neglect with their own children.[3] In light of the trauma and long term consequences abused and neglected children endure, it is imperative that these children obtain timely access to effective mental and behavioral health services in order to overcome the trauma and eliminate the cycle of abuse and neglect.

All children in the child welfare system have access to mental and behavioral health services. However, the manner in which children may access these services depends on whether they remain in their own homes or are removed from their homes and placed in kinship care or foster care.

# Analysis

**Mental and Behavioral Health Services for Children who Remain in Their Homes**
During the course of an abuse or neglect investigation or while providing Family Based Safety Services (FBSS) in the child's home, CPS may determine a child has mental or behavioral health needs.[4] CPS caseworkers receive both classroom and field training to help them identify mental and behavioral health needs, substance abuse, depression and domestic violence. In addition to this training, the Department of Family and Protective Services (DFPS) offers courses for caseworkers on various topics, including the effects of trauma and neglect on neurodevelopment, the risk of teen suicide, child abuse and domestic violence, and substance abuse and mental health concerns.[5]

If a caseworker determines a child has mental or behavioral health needs, the caseworker may coordinate with any of a number of community organizations and resources to ensure that the child receives a mental health assessment and therapeutic services, if needed. Table 1 includes a list of community organizations and resources to which a CPS caseworker may make a referral.

These entities serve a number of populations and are not limited to children and families receiving FBSS services. For example, Local Mental Health Authorities provide services to various individuals with mental or behavioral health needs, which may include children receiving FBSS services.

**Table 1. Organizations and Resources that Conduct Assessments and Provide Services[6]**

| Name | Description |
|---|---|
| **Children's Advocacy Centers (CACs)** | Conduct therapeutic assessments and provide services, including forensic interviewing; coordination of investigations, medical/mental health services and social/family services; trial preparation; parent education; case management; and CPS training courses. Although CACs work with abused and neglected children generally, they specialize in helping child victims of sexual abuse. Funding sources include the CACTX Swalm Grant; city and county governments; foundations; the National Children's Alliance; the Office of Attorney General's Victim's Assistance Program; special events; business organizations; and individual donors. |
| **Community Resource Coordination Groups (CRCGs)** | Local groups comprised of both public and private agencies that coordinate with other agencies and service providers to develop a service plan to meet children's needs. CRCG services are provided at no cost. |
| **DFPS Contract Providers** | Provide case management services, including referrals to community services and referrals back to the CPS caseworker to arrange for additional services (e.g., day care services). Some contractors also act as service providers. DFPS covers the cost of behavioral health assessments and therapeutic services unless available at no cost in the community or another funding source is identified (e.g., Medicaid). |
| **Local Mental Health Authorities (LMHAs)** | Conduct assessments and provide services to eligible individuals not covered by private insurance or Medicaid. Services are funded through the state's General Revenue (GR) Fund. Limited slots are available to receive GR funded services and individuals may be placed on a waiting list for services. |
| **Early Childhood Intervention (ECI)** | A jointly funded state/federal program that conducts assessments and provides services to children ages 0-3 with intellectual or developmental disabilities. Local contractors with the Department of Assistive and Rehabilitative Services provide services in the child's learning environment, child care center, or at home. |
| **Medicaid Providers** | *Texas Health Steps (THSteps) Providers* - conduct well child exams, including behavioral health and developmental screenings and referrals, as needed.<br>*Behavioral Health Providers* - develop treatment plans and provide behavioral health therapy.<br>*Psychologists* - provide psychological testing and may provide behavioral health therapy.<br>*Psychiatrists* - provide diagnoses and treatment, including medication. |
| **Private Mental Health Professionals** | Provide behavioral health services, including individual counseling for children and adults, family therapy, play therapy, psychological evaluations and, if recommended, psychiatric evaluations. CPS caseworkers determine whether the family is covered by private health insurance or Medicaid and refer the family to a plan provider. Individual professionals bill private insurance or Medicaid. |

In addition to these community organizations and resources, a CPS caseworker may also refer a child's mental health records or case files to a DFPS contract provider who is a subject matter

expert (e.g., educational specialist, regional nurse consultant, substance abuse specialist) to review the child's records or case files and make recommendations.[7]

**Mental and Behavioral Health Services for Children in Kinship Care or Foster Care**

*STAR Health Overview*

Children removed from their homes and placed in kinship care or foster care are automatically enrolled in Superior STAR Health (hereinafter referred to as "STAR Health"), the Medicaid program for foster children.[8] STAR Health is a managed care system that provides an array of medical and mental health services.[9] Upon enrollment in STAR Health, the child is immediately eligible for Medicaid services. Within 24-48 hours after a child is removed from the home, DFPS sends STAR Health an eligibility file, triggering outreach by STAR Health to the child's caregiver. Within five days of receiving the child's eligibility file, STAR Health sends enrollment information to the child's caregiver, including an ID card, welcome letter, member handbook, provider directory, and primary care provider selection form.

STAR Health is managed by Superior HealthPlan Network (hereinafter referred to as "Superior") and is intended to provide both coordinated and comprehensive care. Children enrolled in STAR Health are assigned a primary care provider tasked with overseeing and coordinating the child's care.[10] In addition, STAR Health creates and manages a Health Passport for each enrolled child. The Health Passport is an electronic health record that enables CPS caseworkers, medical consenters,[11] and providers to review information relating to the child's medical history, including prior doctor's visits, diagnoses, immunizations, and prescriptions.[12] STAR Health providers are required under contract to use the Health Passport[13] and STAR Health periodically hosts training webinars and sends written materials to providers to educate them about how to use the Health Passport. Information in the child's Health Passport is updated regularly.[14] The Health Passport is not a comprehensive medical record. For example, the child's medical and pharmaceutical history will only be included in the Health Passport if the child was enrolled in Medicaid or the Children's Health Insurance Program (CHIP) prior to removal. Even so, the Health Passport provides more information about the child than was previously available.

Through Integrated Mental Health Services (IMHS), Superior's mental and behavioral health provider, STAR Health provides a number of mental and behavioral health services for children in need of treatment for abuse, neglect, trauma, depression, attachment disorders, and other conditions. These services include inpatient and outpatient mental health services; intensive outpatient services; inpatient and outpatient chemical dependency services; community based services through a local Mental Health/Mental Retardation (MHMR) Center; and partial hospitalization.

Compared to children enrolled in traditional Medicaid and CHIP, children enrolled in STAR Health utilize mental and behavioral health services at a significantly higher rate.[15] For example, almost half of the 49,716 children enrolled in STAR Health from March 2009 through February 2010 received mental or behavioral health services, compared to just 3% of children enrolled in traditional Medicaid or CHIP.[16] Table 2 includes information regarding the specific services these STAR Health enrollees received.

**Table 2. STAR Health Mental and Behavioral Health Services[17]**

| Service Type | Number of Children Receiving Services |
|---|---|
| Outpatient mental health services (individual, family, and group therapy; psychological testing) | 23,591 |
| Inpatient mental health services (psychiatric hospitalization) | 2,303 |
| Community based services through local MHMR Center (rehabilitative skills training, medication management, individual and family therapy, evaluation) | 613 |
| Partial hospitalization[18] | 306 |
| Intensive outpatient services[19] | 256 |
| **Total** | **27,069*** |

*Children may receive more than one type of service.

Children enrolled in STAR Health are automatically authorized to receive mental health services. Therefore, they do not require a primary care provider's referral in order to schedule an appointment with a mental health provider in the IMHS network.[20] Children may receive up to ten therapy sessions. After ten sessions, IMHS will work with the child's primary care provider to develop a plan of care.

A child enrolled in STAR Health may be referred for mental or behavioral health services as a result of the child's Texas HealthSteps checkup or General Health Assessment, or at the request of a number of entities illustrated in Figure 1.

*Medical and Mental Health Assessments*

Texas Health Steps Checkup

Within 30 days of a child entering kinship care or foster care, STAR Health is required under contract to ensure that the child receives a Texas Health Steps (hereinafter referred to as "THSteps") medical checkup.[21] The THSteps checkup is intended to quickly identify any medical, mental health, vision or dental problems.[22] Information about completed THSteps appointments is included in the child's Health Passport.[23] STAR Health THSteps coordinators monitor children's THSteps appointments, send reminder notices of any due or past due appointments, and work with the STAR Health Service Management team to ensure that services are provided in a timely manner.[24] For many children placed in kinship care or foster care, the THSteps checkup may be the child's first opportunity to see a medical professional and the medical professional's first opportunity to identify a child's mental or behavioral health needs.

Although Superior is required under contract to ensure that all children enrolled in STAR Health receive a THSteps checkup within 30 days of enrollment, the reality is that fewer than half of these children actually do. In fact, in 2008, only 18% of children enrolled in STAR Health received a THSteps checkup within 30 days. In 2009, this percentage increased to just 38%. Even data regarding the number of children who received a THSteps checkup within *90* days (60 days beyond contractual requirements) is concerning. In 2008, only 43% of children received a THSteps checkup within 90 days. In 2009, this percentage increased to just 56%.

There are a number of reasons why children may not receive a timely THSteps checkup. For example, data indicates that children in kinship placements are far less likely to receive a timely checkup, compared to children in non-kinship placements (e.g., foster care). In many cases, kinship caregivers are unable to leave work and transport the child to an appointment within the first 30 days of the child's placement. Also, because kinship caregivers may be more familiar with the child's medical history than a foster care provider unrelated to and unfamiliar with the child, the caregiver may not seek immediate medical treatment for the child. In some cases, CPS caseworkers will assume the responsibility of transporting a child to and from his/her appointments. However, these caseworkers often struggle to balance this responsibility with their demanding caseloads. For each of these reasons, very few children enrolled in STAR Health receive a timely THSteps checkup.

In an effort to ensure children receive a timely THSteps checkup, Superior is implementing the following procedures:

- appointing two STAR Health kinship outreach specialists and directing outreach to new kinship caregivers;
- developing a flier for kinship caregivers that includes information about the importance of preventative care, THSteps, the Medical Transportation Program, Superior Transportation, and STAR Health kinship outreach specialists; and
- dedicating a STAR Health Member Service Manager to participate in the statewide STAR Health Outreach to Kinship Caregivers and Foster Parents Committee.

In addition to these new procedures, the Health and Human Services Commission (HHSC) should encourage Superior to increase the number of providers who offer appointments after hours and on weekends. This would give caregivers who cannot take time off of work greater flexibility to ensure the children in their care receive a timely THSteps checkup and other needed services. In addition, increasing the number of providers offering extended and weekend hours should ensure that children do not have to miss school to go to doctor's appointments, and should reduce the need to arrange for third party transportation (via a CPS caseworker, the Medicaid Medical Transportation Services Program, or Superior Transportation) to transport children to their appointments. Table 3 includes information regarding the number (and percent) of STAR Health providers currently offering extended and weekend hours.

**Table 3. STAR Health Providers Offering Extended and Weekend Hours**

| | **Providers** | **Providers with Extended Hours** | **Providers with Weekend Hours** |
|---|---|---|---|
| **STAR Health Primary Care Providers** | 6,527 | 822 (12.6%) | 657 (10.1%) |
| **STAR Health Behavioral Health Providers** | 3,270 | 1,444 (44.2%) | 771 (23.6%) |

To ensure children receive a timely THSteps checkup, STAR Health should work with the CPS caseworker and the child's caregiver by contacting them if the child does not receive a checkup

within 30 days of placement; reminding the caseworker and caregiver that the checkup is mandatory; and offering to provide transportation to the checkup, if needed. Moreover, STAR Health providers should include a screening for depression and other common mental illnesses in the THSteps checkup. Since this checkup may be the child's first opportunity to see a medical professional, including a mental health screening may help providers quickly identify a child with mental or behavioral health needs.

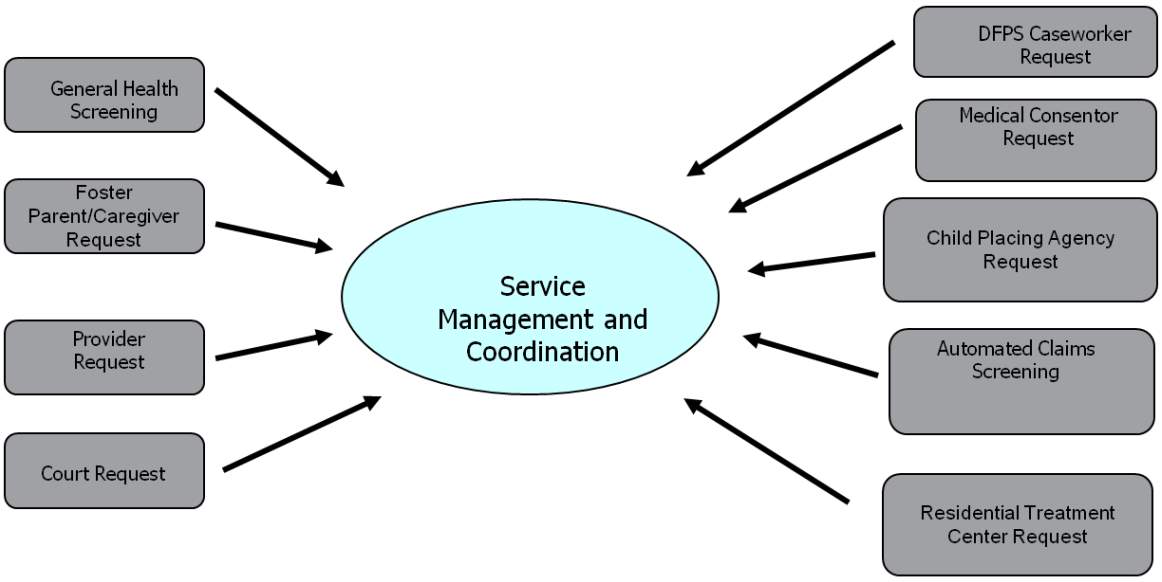
STAR Health General Health Assessment

Within 30 days of a child entering kinship care or foster care and after each placement change, STAR Health Service Coordinators conduct a general health assessment with the assistance of the child's caregiver and if needed, the child's CPS caseworker.[25] Unlike the THSteps checkup, which includes a "face to face" visit with a health care provider, the general health assessment is conducted telephonically by someone who is typically not a health care professional. This assessment includes an overview of any medical or behavioral health issues experienced by the child and requiring regular doctor visits; medications; needed services, including mental health or counseling; planned appointments, tests, surgeries, or other health services; prior diagnoses, hospitalizations and surgeries; allergies; and diet. In addition to health related issues, the assessment covers the child's academic history, current placement (including placement type) and number of placements within the past six months. Information collected during a general health assessment is not included in the child's Health Passport.[26]

Considering the breadth of information STAR Health seeks to obtain when conducting a general health assessment, it may be helpful to include the child (if he/she is of a mature age) and the child's biological parents or guardians in this process. This is especially true for children in foster care. If STAR Health only speaks with the caseworker and caregiver, both of whom may have only known the child for a few days, critical information about the child's health, academic, and placement history may not be captured.

In the event that information obtained during the general health assessment suggests a child may need mental or behavioral health services, the STAR Health Service Coordinator will make a referral to a Superior behavioral health clinical supervisor. The supervisor will conduct an additional assessment to determine the child's mental health needs. If the child needs a mental health assessment, the Service Coordinator will help the child set up an appointment with a mental health provider. The provider may be a psychiatrist, psychologist, licensed clinical social worker, licensed professional counselor or licensed marriage and family therapist. In addition to a referral based on the general health assessment, a child may be referred for a mental health assessment at the request of a number of entities, as illustrated in Figure 1.[27] Even if a child does not immediately appear to require mental health services, any of the entities featured in Figure 1 may request that the child receive a mental health assessment at any time.

**Figure 1. STAR Health Service Management[28] Access Points**




Mental health assessments are intended to identify which services will satisfy the child's mental or behavioral health needs.[29] Typically, these assessments are conducted in the STAR Health provider's office or the child's home with the child and his/her caregiver present. An assessment may determine whether the child has a diagnosable mental health or substance use disorder and identify any appropriate treatment goals to reduce or resolve the child's symptoms. Assessments usually last between 60-90 minutes. However, if the assessment includes psychological testing, several sessions may be required. In the event that the mental health assessment indicates a child needs mental or behavioral health services, a licensed STAR Health Service Manager will develop a Health Care Service Plan (HCSP) with the assistance of the child's caregiver and caseworker.[30] The HCSP is placed on the child's Health Passport and is intended to ensure the child's health care needs are met and that all services are coordinated.

*Accessing Mental or Behavioral Health Services*

In some areas, children enrolled in STAR Health must travel long distances to receive mental or behavioral health services because there are simply no providers in their communities. For example, 204 of Texas' 254 counties do not have a single child and adolescent psychiatrist.[31] Superior is required under contract to ensure that children have access to mental health providers. This requires Superior to ensure that children living in counties with over 50,000 residents must travel no more than 30 miles (60 miles round trip) to see a mental health provider. For children in counties with fewer than 50,000 residents, Superior must ensure these children must travel no more than 75 miles (150 miles round trip) to see a provider. According to a STAR Health behavioral health accessibility report published in June 2010, over 1,000 children live in counties with no mental health provider.[32] As a result, many of these children must travel 60 to 150 miles round trip just to see the nearest provider.[33] This shortage of mental health providers is not unique to STAR Health. As discussed in greater detail in Interim Charge #5, there is generally a shortage of mental health providers in Texas.

Children may encounter a number of transportation related barriers to receiving needed mental health services. These include living in a rural area with no mental health provider, not having a vehicle to transport the child to appointments, and being unable to take time off of work to transport the child to his/her appointments. STAR Health offers two solutions to eliminate these barriers: the Medicaid Medical Transportation Services Program (hereinafter referred to as the "Transportation Program") and telemedicine.

Medicaid Medical Transportation Services Program

The Transportation Program provides transportation for children enrolled in STAR Health and their caregivers, if the caregiver has no other way to get the child to his/her appointment. Caregivers need only call the Transportation Program two days before the child's doctor's appointment to schedule transportation services.[34] In addition to providing transportation to doctor's appointments, the Transportation Program provides gas money for family members, neighbors or other volunteers who transport the child to his/her doctor's appointment.[35] If transportation is not covered by the Transportation Program, Superior may authorize transportation via bus, van, or cab to the child's appointment.[36] This service is provided at no cost through STAR Health.

Telemedicine

As of August 2010, 88 Texas counties do not have a STAR Health mental health provider. In order for children in these counties to access needed mental health services, it may be necessary to provide services through telemedicine. Telemedicine is the delivery of health care through "face to face" interactive video communications by a provider located at a site other than where the patient is located,[37] for the purposes of evaluation, diagnosis, consultation, or treatment.[38] The provision of telemedicine services involves a patient site presenter[39] responsible for presenting the patient for services and a distant site provider responsible for delivering the services. The presenter—often a nurse, counselor, social worker, or behavioral health technician—accompanies the child during each session and assists the child as needed.[40] Currently, children enrolled in STAR Health can only receive telemedicine services at a state hospital, state supported living center, or in a rural[41] or underserved area.[42] Reimbursable telemedicine services include consultations, office visits, psychiatric diagnostic interviews, pharmacologic management, and psychotherapy.[43]

In recent years, the number of traditional Medicaid providers delivering services through telemedicine and the number of telemedicine services provided have steadily increased. This increase is a result of expanded coverage of telemedicine services, improved tracking, and other initiatives designed to improve access to care.[44] Table 4 illustrates the steady increase in traditional Medicaid telemedicine providers and psychiatric services provided to Medicaid clients from FY 2005 through 2009.

**Table 4. Medicaid Telemedicine Provider Participation FY 2005–2009[45]**

| Fiscal Year | Providers | Psychiatric Diagnostic Interviews | Psychiatric Treatments |
|---|---|---|---|
| 2005 | 14 | 15 | 2 |
| 2006 | 16 | 56 | 87 |
| 2007 | 25 | 213 | 376 |
| 2008 | 43 | 378 | 437 |
| 2009 | 46 | 1,162 | 316 |

Despite this upward trend in the number of Medicaid providers delivering services through telemedicine and the number of telemedicine services provided, STAR Health providers almost never provide services through telemedicine. HHSC's contract with Superior for STAR Health requires Superior to contract with providers having telemedicine capabilities and to include information on providers with telemedicine capabilities in the STAR Health Provider Directory.[46] However, STAR Health contracts with only 12 facilities (11 MHMR Centers and one clinic) that provide telemedicine services.[47] In the past two years, providers at these facilities collectively filed only 16 claims for telemedicine services.[48]

HHSC has undertaken a number of efforts to encourage greater use of telemedicine among Medicaid providers, including expanding the Texas Medicaid telemedicine benefit in April 2009 to:

- remove limitations on the location of the distant site;
- add office visits, pharmacologic management, psychiatric diagnostic interview examinations, and individual psychotherapy as allowable telemedicine services;
- expand the types of health professionals who can act as patient site presenters; and
- provide for the reimbursement of a facility fee for the patient site location.[49]

In addition, HHSC contracted with the University of Texas Medical Branch (UTMB) to establish the UTMB/HHSC TeleHealth network for Children (UTNC) to provide pediatric psychiatry services to Medicaid enrolled children through telemedicine. There are currently 10 patient sites in East and Central Texas. Notwithstanding these efforts, the dearth of STAR Health providers' claims for telemedicine services indicates that more needs to be done to ensure that children enrolled in STAR Health have access to mental and behavioral health services provided through telemedicine.

Community MHMR Centers

As indicated in Table 2, from March 2009 through February 2010, 613 children received community based mental or behavioral health services through a local MHMR Center. Texas' 39 community MHMR Centers are in the STAR Health provider network. However, some child welfare advocates are concerned that very few children enrolled in STAR Health are utilizing MHMR Centers for services. This may occur for several reasons. First, as discussed previously, IMHS does not require an authorization for children enrolled in STAR Health to receive mental health services. The child's medical consenter can contact a mental health provider directly to schedule an evaluation and up to nine therapy sessions for the child. If the child's medical consenter does not know the local MHMR Center is an option, he/she will not contact the Center for services.

Second, children enrolled in STAR Health may not utilize MHMR Centers due to the long wait times to receive services. Some MHMR Centers are operating at capacity and are unable to provide services for as many as four to 12 weeks.[50] In these cases, a child may seek out another mental health provider who can begin treating the child sooner. Finally, some children may not receive services through a local MHMR Center if the Center specializes in serving only children with serious mental illness or provides only full packages of services (as compared to providing just one or two needed services).

In order to alleviate some of the barriers to children accessing services through a local MHMR Center, HHSC, DFPS and MHMR senior leadership have scheduled meetings to further discuss these issues.[51] In addition, DFPS is educating residential providers (e.g., foster family home staff; foster group home staff; residential treatment center staff; emergency shelter staff; private Child Placing Agency staff) about the availability of MHMR Centers and the services they provide.[52] In addition to these measures, HHSC should undertake additional efforts to increase awareness of community MHMR Centers as a resource for children in STAR Health and whenever possible and practicable, HHSC should encourage greater use of local MHMR Centers and substance abuse clinics.

*Psychotropic Medications*

A number of child welfare advocates are concerned that children in foster care are prescribed multiple psychotropic medications (e.g., antidepressants, antipsychotics, antianxiety drugs, lithium), resulting in overmedication of the child. A recent news article regarding psychotropic medication use among Texas foster children discussed one former foster child who was prescribed nine psychotropic medications after seeing a psychiatrist for only 15 minutes.[53]

CPS policy requires the child's medical consenter to be informed of the child's health care needs, consent to each psychotropic medication, and participate in each of the child's appointments with the prescribing physician.[54] In addition, medical consenters must notify DFPS by the next business day after a child is prescribed a psychotropic medication or controlled substance.[55] A summary of the child's medical care, including detailed information about any psychotropic medications, must be contained within the judge's court report, which is shared with all parties involved in the case. As an additional precaution, it would be helpful for the medical consenter to notify other parties involved in the case whenever a child is prescribed a psychotropic medication.

In 2005, HHSC, the Department of State Health Services, and DFPS issued a series of best practice guidelines collectively titled “Psychotropic Medication Utilization Parameters for Foster Children” (hereinafter referred to as "Parameters").[56] Updated in 2007 and currently under review, the Parameters are intended to serve as a resource for physicians and other clinicians treating children diagnosed with a mental disorder. The Parameters provide eight circumstances under which STAR Health should review a child's medication regimen.[57] These include:

- The child does not have a documented mental health diagnosis.
- Five or more psychotropic medications have been prescribed concurrently.
- The child has concurrently been prescribed:
    - two or more antidepressants, antipsychotics, or stimulants; or
    - three or more mood stabilizers.

- The prescribed psychotropic medication is not consistent with appropriate care for the patient's diagnosed mental disorder or symptoms.
- Multiple psychotropic medications for a given mental disorder are prescribed before prescribing a single medication.
- The psychotropic medication dose exceeds usually recommended doses.
- Psychotropic medications are prescribed for very young children.
- Prescribing has been done by a primary care provider for a diagnosis other than attention deficit hyperactive disorder, uncomplicated anxiety disorders, or uncomplicated depression.[58]

In an effort to ensure children are prescribed psychotropic medications only when appropriate and necessary, STAR Health conducts psychotropic medication utilization reviews based on information obtained during a general health screening or automated pharmacy claims screening and upon request by CPS, CASA volunteers, foster parents, attorneys, child placing agencies, or family court judges.[59] According to Medicaid prescription and medical claims data from FY 2002 through 2009, children's use of psychotropic medications is on the decline.[60]

*Trauma-Informed Care Training*

In the child welfare context, "trauma-informed care" refers to understanding the impact of trauma on a child's physical, mental, and emotional health and behaviors, and tailoring programs and services to reduce the impact of trauma on children in the CPS system.[61] As mentioned previously, children in DFPS' substitute care have experienced profound trauma due to abuse or neglect perpetrated by those closest to them, as well as the secondary trauma of being removed from the only, albeit unsafe, home they know. In light of the trauma children in the CPS system have experienced, it is critical that professionals interacting with these children understand the effects of trauma on their physical, mental, and behavioral health and apply appropriate treatments and interventions.

Trauma-informed care has garnered both national and local support. The Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration have identified trauma-informed care as a best practice for child welfare. In addition, the Texas Legislature recently directed DFPS to include training in trauma-informed programs and services in any training the department provides to foster parents, adoptive parents, kinship caregivers, and CPS caseworkers.[62] At no additional cost to the state, IMHS is providing regional evidence based trauma-informed care training seminars to CPS caseworkers and supervisors.[63] This training is designed to promote an understanding of the effects of trauma on children, early identification of trauma, and the use of evidence based interventions and treatment strategies.[64] DFPS also added trauma-informed care training as a certification requirement for CPS caseworkers and supervisors.

In addition to the training provided to CPS caseworkers and supervisors, IMHS provides shorter training sessions to CPS program directors, case aides, foster parents, kinship caregivers, CASA volunteers, Child Placing Agency staff, residential treatment center staff, and judges,[65] and IMHS plans to adapt its training for other child welfare advocates and professionals in the future.[66]

In order to reinforce caseworkers and supervisors' understanding of the effects of trauma on children and ensure their continued application of evidence based treatment strategies, DFPS should require CPS caseworkers and supervisors to receive annual trauma-informed care refresher training. In addition, DFPS should offer trauma-informed care training opportunities to Children's Advocacy Center[67] staff, MHMR Center therapists and domestic violence shelter staff. Extending this training to more of the individuals likely to encounter a child in the CPS system should ensure that all treatments and interventions are trauma-informed. Finally, DFPS should include trauma-informed care training in the department's parenting class curriculum for parents who have contact with CPS[68] and should study the effectiveness of trauma-informed care training for CPS caseworkers and supervisors, foster parents, adoptive parents, kinship caregivers, and other individuals receiving this training.

In order to ensure that mental health providers (e.g., psychiatrists, psychologists, licensed professional counselors) also understand the impact of trauma on a child's physical, mental and emotional health and behaviors and tailor their programs and services accordingly, HHSC should require mental health providers to receive training in grief and loss therapy, sexual abuse therapy, physical abuse therapy, and trauma-informed care, under HHSC's contract with Superior for STAR Health.

**Other Considerations**

*STAR Health Annual Quality of Care Report*

According to a recent report by the University of Florida Institute for Child Health Policy (hereinafter referred to as the "Institute"), Texas' external quality review organization for Medicaid Managed Care and CHIP, STAR Health performed above national averages in follow up care for enrollees hospitalized for mental illness.[69] Among those hospitalized for a mental illness, 52% received follow up care within seven days of being discharged and 83% received follow up care within 30 days of discharge.[70] However, STAR Health performed below national benchmarks in other areas, including mental health readmission rates and the average number of prescriptions per member per year.[71]

Mental Health Readmission Rates

Mental health readmission rates are often used as an indicator of an adverse outcome, potentially resulting from efforts to contain behavioral health care costs (e.g., by reducing the initial hospital length of stay).[72] Overall, 20% of STAR Health enrollees were readmitted to the hospital within 30 days of an inpatient stay for mental health. Among enrollees age 19 and older, this percentage increased to 33%.[73] The Institute suggested this may be due to a lack of appropriate transitional services (including access to outpatient mental health services) and recommended that HHSC examine the availability and coordination of transitional living services and outpatient mental health services to reduce the readmission rate for young adults with mental health needs.[74]

Prescriptions

According to the Institute's report, the average annual number of prescriptions per member in the STAR Health program was 16.30, compared to a national average of only 10.30.[75] Among enrollees ages 10–17, this number increased to 24.85 prescriptions per year.[76]

Although the Institute's report was submitted in November 2009, the report was not published on HHSC's website until May 2010. In addition, the measurement period for quality indicators in the report was April 1, 2008 (when STAR Health began) through August 31, 2008. Because this report evaluated the quality of services delivered over two years ago, it is unclear whether the Institute's findings are still accurate. A subsequent report would be helpful to better determine the quality of services currently provided by STAR Health.

*STAR Health Premium*

For each child enrolled in STAR Health, the state pays a monthly $720 premium. Almost 50% of the premium is attributed to medical claims, 40% to capitated services (including mental health services), and 10% to administrative costs. Table 5 includes detailed information regarding the STAR Health monthly premium.

**Table 5. FY 2010 STAR Health Monthly Premium[77]**

| Rate Component | Cost | Percent |
|---|---|---|
| Medical claims, including hospital, physician, private duty nursing, home health, therapies | $343.97 | 47.75% |
| Capitated services, including mental health, dental, vision, primary care | $280.13 | 38.88% |
| Administrative costs[78] | $66.34 | 9.21% |
| Other | $29.98 | 4.16% |
| **Total Rate** | **$720.42** | **100%** |

*Private Duty Nursing*

Currently, between 300–400 children enrolled in STAR Health require private duty nursing, a benefit in the THSteps Comprehensive Care Program. Private duty nursing is skilled nursing for clients requiring individualized, continuous care beyond the level of skilled nursing visits normally authorized for clients receiving Medicaid home health services.[79] Private duty nursing is considered medically necessary if a person requires "continuous, skillful observation and judgment to maintain or improve health status; and

- is dependent on technology to sustain life; or
- requires ongoing and frequent skilled interventions to maintain or improve health status, and delayed skilled intervention is expected to result in deterioration of a chronic condition; loss of function; imminent risk to health status due to medical fragility; or risk of death."[80]

Many children receiving private duty nursing services are medically fragile and require the assistance of ventilators 24 hours per day. Private duty nursing is provided by a registered nurse, licensed vocational nurse, or as a delegated service provided by a qualified aide through a licensed home and community support services agency.[81] Private duty nursing services are provided at a cost of $4–5 million per month. Currently, 151 STAR Health enrollees receive private duty nursing in only 51 homes. Often, as many as 8–10 children receiving private duty nursing services reside in one foster home, yet the nurse to patient ratio is 1:1.

HHSC convened a workgroup to determine how to reduce costs associated with private duty nursing in STAR Health while continuing to ensure children's safety and provide all necessary services. In May 2010, the workgroup presented the following recommendations to HHSC:

- Pursue a nurse to patient ratio greater than 1:1 when multiple Medicaid enrolled children receive private duty nursing services in the same home. This option is allowed under current medical policy but is not regularly utilized.
- Implement accepted and vetted clinical criteria to manage utilization of hours for private duty nursing services. The criteria would need to include any medically necessary private duty nursing services as required by THSteps and must comply with the *Alberto N.* settlement agreement.
- Require clients who are candidates for private duty nursing to undergo an independent assessment, which ideally would look at the client's overall needs.[82]

In addition to these recommendations, HHSC is conducting a number of activities to improve the private duty nursing program, including:

- Revising Medicaid administrative rules to emphasize the continuum of care available to these clients. Currently, the rules define each individual service, which leads to compartmentalization in service delivery. Combining nursing and related services into one rule will encourage the use of the full array of services.
- Collaborating with Texas A&M University to develop a comprehensive assessment instrument that could be used for attendant care, private duty nursing, and other skilled nursing services (including delegated nursing tasks). All services could be assessed at the same time by a registered nurse. Such a tool would allow for a more appropriate determination of the type of care and provider needed.

*Independent Assessments*

Currently, licensed Home and Community Support Services Agencies (HCSSAs) conduct an assessment to determine the type and amount of services the HCSSA needs to provide, which could potentially result in a conflict of interest. Although STAR Health periodically reviews services, it does not conduct a separate assessment. HHSC should contract with an independent entity to complete new client assessments and any required reassessments (e.g., for continued prior authorization of services).

# Recommendations

1. **Direct the Department of Family and Protective Services to provide Child Protective Services caseworkers and supervisors annual refresher training in trauma-informed care.**

2. **Direct the Department of Family and Protective Services to offer trauma-informed care training to CASA volunteers, Child Advocacy Center staff, MHMR Center therapists, and domestic violence shelter staff.**

3. **Direct the Department of Family and Protective Services to include trauma-informed care training in the department's parenting class curriculum for parents who have contact with Child Protective Services.**

4. **Direct the Department of Family and Protective Services to study the effectiveness of trauma-informed care training for Child Protective Services caseworkers and supervisors, foster parents, adoptive parents, kinship caregivers, and others receiving this training.**

5. **Encourage the Health and Human Services Commission to require STAR Health mental health providers (e.g., psychiatrists, psychologists, licensed professional counselors) to receive training in grief and loss therapy, sexual abuse therapy, physical abuse therapy, and trauma-informed care.**

6. **Require STAR Health to ensure that children receive a timely THSteps checkup and require contracted providers to screen children for depression and other common mental illnesses during the child's THSteps checkup.**

7. **Encourage STAR Health providers to offer appointments after hours and on weekends.**

8. **Encourage the Health and Human Services Commission to undertake additional efforts to increase awareness of community MHMR Centers are a resource for children in STAR Health. In addition, whenever possible and practicable, the Health and Human Services Commission should encourage greater use of local MHMR Centers and substance abuse clinics.**

9. **Encourage the Health and Human Services Commission to commission a subsequent report evaluating the quality of care in the STAR Health managed care program.**

10. **Direct the Health and Human Services Commission to reduce costs associated with private duty nursing.**

11. **Direct the Health and Human Services Commission to reduce costs associated with certain non-mental health therapies, including physical therapy, occupational therapy, and speech therapy.**

12. **Require a state entity or entity that the Health and Human Services Commission or the Department of Aging and Disability Services contracts with to conduct independent assessments of individuals before they may begin receiving services from a home and community support services agency.**

13. **Direct the Department of Family and Protective Services to restructure its Level of Care based reimbursement system to reward improvements in children's well being (as opposed to reimbursing caregivers based on the child's level of care).**

14. **Direct the Health and Human Services Commission to develop a plan to increase STAR Health providers' use of telemedicine.**

**15. Encourage the Department of Family and Protective Services to contract with providers that can provide individualized continuums of care (e.g., multiple placement settings within a single agency), particularly as children transition from residential environments to foster home settings.**

**16. Encourage the Health and Human Services Commission to require STAR Health providers to receive training in post traumatic stress disorder and attention deficit hyperactivity disorder under contract requirements.**

**17. Require the child's medical consenter to inform the parties involved in the case when a child is placed on a psychotropic medication.**

---

[1] Texas Department of Family and Protective Services (DFPS) Annual Report and Data Book 2009, p. 39 (hereinafter referred to as "DFPS Annual Report and Data Book"). Actual incidents of child abuse and neglect may be higher, since not every incident of abuse/neglect is reported.
[2] Child Welfare Information Gateway. Available online at www.childwelfare.gov/pubs/factsheets/long_term_consequences.cfm
[3] *Id.*
[4] During the Senate Committee on Health & Human Services hearing on March 11, 2010, DFPS Commissioner Anne Heiligenstein mentioned CPS caseworkers are trained to identify behavioral health needs and indications of substance abuse, depression and domestic violence. To access the archived video of this hearing, go to http://www.senate.state.tx.us/75r/senate/commit/c610/c610.htm and click on March 11, 2010.
[5] Information provided by DFPS via email dated April 7, 2010.
[6] Information in Table 1 provided by DFPS.
[7] Services provided by DFPS subject matter experts are funded by DFPS using purchased client services funds.
[8] See "Quick Guide to STAR Health for Caregivers," available online at http://www.dfps.state.tx.us/About/Renewal/CPS/medical.asp#quick (last accessed October 25, 2010). STAR Health is also provided to young adults up to age 22 who have a voluntary foster care placement and young adults under age 21 who are no longer in foster care and are receiving transitional Medicaid benefits.
[9] See "How STAR Health Began," available at http://www.dfps.state.tx.us/About/Renewal/CPS/medical.asp (Last accessed July 1, 2010).
[10] See "STAR Health: Statewide Healthcare System," available at http://www.dfps.state.tx.us/About/Renewal/CPS/medical.asp (Last accessed July 1, 2010).
[11] A medical consenter is the person a court authorizes to consent to medical care for a child in state conservatorship and participate in the child's medical appointments. The medical consenter may be the child's foster parent, a relative, or the child's CPS caseworker. See "STAR Health Member Handbook," p.6 available online at http://www.fostercaretx.com/wp-content/uploads/2008/06/6-2010-Superior-Star-Health-Final.pdf (Last accessed August 9, 2010).
[12] See "What is the Health Passport?" available at http://www.fostercaretx.com/health-passport/health-passport-faqs/#what (Last accessed June 30, 2010).
[13] Providers receive information about the Health Passport and provider requirements in the provider contract and Provider Manual issued at the provider's initial enrollment and annually thereafter.
[14] See "How often is the information in the Health Passport updated?" available at http://www.fostercaretx.com/health-passport/health-passport-faqs/#what (Last accessed June 30, 2010).
[15] See "Annual Chart Book: Texas Medicaid Managed Care STAR Health Quality of Care Measures," submitted November 30, 2009. Available online at http://www.hhsc.state.tx.us/reports/2010/Quality_Care_ReportFY08.pdf (last accessed October 25, 2010).
[16] According to HHSC, from March 1, 2009 through February 28, 2010, 49,716 children were enrolled in STAR Health. Of these, 23,667 (or 47.6%) received mental or behavioral health services. During this same period, 441,997 children were enrolled in Medicaid or CHIP and only 14,518 (or 3.3%) received these services.
[17] Table prepared using data provided by DFPS and HHSC.

[18] Partial hospitalization services address individualized treatment needs through facility based programs that include onsite access to nursing, psychiatric care and behavioral interventions. Treatment is similar in intensity to acute hospitalization services. However, the services are not available 24 hour a day; the individual must be able to return to the community between sessions.
[19] Intensive outpatient programs must provide an integrated program of rehabilitation, education, counseling and therapeutic interventions to address an individual's mental health or substance abuse needs. Each individual has a specific treatment plan with the goal of symptom reduction and improvement in functioning sufficient to return the individual to outpatient level of care for follow up.
[20] "STAR Health Member Handbook," p. 9 available online at http://www.fostercaretx.com/wp-content/uploads/2008/06/6-2010-Superior-Star-Health-Final.pdf (Last accessed October 26, 2010).
[21] In Texas, the Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is referred to as the Texas Health Steps (THSteps) Program. For additional information regarding the THSteps checkup, see the Texas Medicaid Provider Procedures Manual: Vol. 2 Children's Services Handbook available online at http://www.tmhp.com/THSteps/default.aspx#1 (Last accessed July 1, 2010).
[22] See "Member Stakeholder Orientation" presentation, slide 20, online at http://www.dfps.state.tx.us/About/Renewal/CPS/medical.asp (Last accessed October 25, 2010).
[23] Information provided by HHSC via email dated October 28, 2010.
[24] See "Member Stakeholder Orientation" presentation, slide 15, online at http://www.dfps.state.tx.us/About/Renewal/CPS/medical.asp (Last accessed October 25, 2010).
[25] DFPS Presentation to Senate Health & Human Services Committee on March 11, 2010, slide 8. Available online at http://www.dfps.state.tx.us/documents/about/Presentations/2010-03-11_Senate_Charge_13.pdf (Last accessed October 27, 2010).
[26] Information provided by HHSC via email dated October 28, 2010.
[27] *Id.* at slide 10.
[28] Service Management is case management for children with higher medical or mental health service needs. See "Quick Guide to STAR Health for Caregivers," available online at http://www.dfps.state.tx.us/About/Renewal/CPS/medical.asp#quick (last accessed October 25, 2010).
[29] *Id.* at slide 11.
[30] *Id.* at slide 12.
[31] Information provided by DFPS via email dated April 7, 2010. Under STAR Health, Child and Adolescent Psychiatrists are available to consult with any physician regarding prescriptions and other care for children in DFPS' substitute care.
[32] Information provided by HHSC via email dated July 15, 2010.
[33] *Id.*
[34] "STAR Health Member Handbook," p. 17 available online at http://www.fostercaretx.com/wp-content/uploads/2008/06/6-2010-Superior-Star-Health-Final.pdf (Last accessed October 26, 2010).
[35] *Id.* at p. 18.
[36] Information provided by HHSC via email dated April 7, 2010.
[37] The patient site location is limited to a state hospital, state supported living center, or if in a rural or underserved area, a physician office, hospital, rural health clinic, federally qualified health center, intermediate care facility for persons with mental retardation, community center, or local health department. *See* 1 Tex. Admin. Code §354.1430(5).
[38] 1 Tex. Admin. Code §354.1430(1). *See also* 1 Tex. Admin. code §354.1432(a)(1).
[39] The patient site presenter is an individual at the patient site who introduces the patient to the distant site provider for examination, and to whom the distant site provider may delegate tasks and activities. *See* 1 Tex. Admin. Code §354.1430(4). The patient site presenter must be licensed or certified to perform health care services. For more information, see "Telemedicine Medical Services in Texas Medicaid," Biennial Report to the Texas Legislature, December 2010, p.2. Available online at http://www.hhsc.state.tx.us/reports/2010/Telemedicine-Medical-Services-0910.pdf (last accessed October 25, 2010).
[40] Integrated Mental Health Services Behavioral Health Provider Manual, p. 16. Available online at http://www.cenpatico.com/providers/forms/texas-and-foster-care/ (Last accessed July 1, 2010).
[41] The U.S. Census Bureau generally defines a rural area as a county with a population of 50,000 or less.
[42] 1 Tex. Admin. Code §354.1430(5).
[43] 1 Tex. Admin. Code §354.1432(a)(2). Reimbursable telemedicine services exclude telephone conversations, chart reviews, and email and facsimile transmissions. In addition, THSteps visits are not reimbursed if performed via

telemedicine. However, any health care or treatment provided via telemedicine following a THSteps visit for conditions identified during a THSteps visit may be reimbursed.
[44] *Id.*
[45] "Telemedicine Medical Services in Texas Medicaid," Biennial Report to the Texas Legislature, December 2010, Appendix B and C. Available online at http://www.hhsc.state.tx.us/reports/2010/Telemedicine-Medical-Services-0910.pdf (last accessed October 25, 2010).
[46] Information provided by DFPS via email dated April 29, 2010.
[47] Information provided by HHSC via email dated July 15, 2010.
[48] Information provided by DFPS via email dated April 29, 2010.
[49] *Id.*
[50] Information provided by HHSC via email dated October 28, 2010.
[51] *Id.*
[52] *Id.*
[53] "Systemic barriers keep foster children medicated." Heidi Zhou-Castro, News8Austin.com. Available online at http://www.news8austin.com/content/headlines/274886/systemic-barriers-keep-foster-children-medicated (last accessed October 28, 2010).
[54] Information provided by DFPS via email dated October 28, 2010.
[55] *Id.*
[56]Additional information is available online at http://www.dshs.state.tx.us/mhprograms/psychotropicmedicationfosterchildren.shtm (Last accessed October 27, 2010).
[57] Psychotropic Medication Utilization Parameters for Foster Children, Texas Department of State Health Services, pp. 5-6. Available online at http://www.dshs.state.tx.us/mhprograms/pdf/PsychotropicMedicationUtilizationParametersFosterChildren.pdf (last accessed October 27, 2010).
[58] *Id.*
[59] DFPS Presentation to Senate Health & Human Services Committee on March 11, 2010, slide 17. Available online at http://www.dfps.state.tx.us/documents/about/Presentations/2010-03-11_Senate_Charge_13.pdf (Last accessed October 27, 2010).
[60] For additional information, see " Update on the Use of Psychoactive Medications in Texas Foster Children Fiscal Years 2002 – 2009," Texas Health and Human Services Commission. Available online at http://www.hhsc.state.tx.us/medicaid/OCC/psychoactive_medications.html (last accessed October 27, 2010).
[61] See "What is Trauma-Informed Care?," Substance Abuse and Mental Health Services Administration, National Center for Trauma-Informed Care. Available online at http://www.samhsa.gov/nctic/trauma.asp (last accessed October 25, 2010).
[62] HB 1151 (81R; Thompson/West).
[63] DFPS Presentation to Senate Health & Human Services Committee on March 11, 2010, slides 20-21. Available online at http://www.dfps.state.tx.us/documents/about/Presentations/2010-03-11_Senate_Charge_13.pdf (Last accessed October 27, 2010). IMHS staff conducting regional training seminars use the Child Welfare Trauma Training Toolkit developed by SAMHSA's National Child Traumatic Stress Network (NCTSN). Additional information regarding NCTSN organizational members that have established trauma-informed systems of care is available online at http://www.nctsnet.org/nccts/nav.do?pid=abt_ntwk#pageTop (last accessed October 26, 2010).
[64] *Id.* DFPS also offers CPS caseworkers ongoing training in topics including the effects of trauma and neglect on a child's neurodevelopment.
[65] Information provided by DFPS via email dated October 27, 2010.
[66] *Id.*
[67] Some Child Advocacy Centers, such as Alliance for Children, are already providing this training. See Nancy Hagan's presentation to the Senate Health & Human Services Committee on March 11, 2010. Available online at http://www.senate.state.tx.us/75r/senate/commit/c610/h2010/h031110a.htm (Last accessed October 27, 2010).
[68] Additional information regarding DFPS parenting classes is available online at http://www.dfps.state.tx.us/Child_Protection/About_Child_Protective_Services/parenting.asp (last accessed October 27, 2010).
[69] See "Annual Chart Book: Texas Medicaid Managed Care STAR Health Quality of Care Measures," submitted November 30, 2009, p. 1. Available online at http://www.hhsc.state.tx.us/reports/2010/Quality_Care_ReportFY08.pdf (last accessed October 25, 2010).

[70] *Id.* at p. 12.
[71] *Id.* at p. 1.
[72] *Id.* at p. 13.
[73] *Id.*
[74] *Id.* at p. 14.
[75] *Id.* at p. 18.
[76] *Id.*
[77] Table prepared using data provided by HHSC.
[78] Services included in the administrative costs include psychotropic medication utilization review; Health Passport; the 24-hour Nurse Line; and training of DFPS staff.
[79] 1 Tex. Admin. Code §363.303(13).
[80] 1 Tex. Admin. Code §363.309.
[81] 1 Tex. Admin. Code §363.303(13).
[82] Information provided by HHSC during meeting with DFPS and HHSC on April 28, 2010.

Interim Charge #14A: *Monitor the implementation of legislation addressed by the Senate Committee on Health & Human Services, 81st Legislature, Regular and Called Sessions, and make recommendations for any legislation needed to improve, enhance, and/or complete implementation.*

- *Monitor Department of Family and Protective Services' implementation of the U.S. Fostering Connections Act, including the new Kinship Care program. Include recommendations on how to optimize the use of monetary assistance to qualified relative caregivers.*

# Background

As of August 2010, 17,118 Texas children were in foster care[1] and in the past year, 1,431 aged out of foster care.[2] Compared with their peers, outcomes for youth who age out of foster care are dismal. They are less likely to graduate high school or attend college and are more likely to experience joblessness, homelessness, mental illness (e.g., depression, anxiety), substance abuse, poor health outcomes, early parenthood and criminal behavior.[3]

In an effort to promote permanency[4] and improve outcomes for children in the child welfare system, the federal government enacted the Fostering Connections to Success and Increasing Adoptions Act of 2008 (H.R. 6893/Pub. L. No. 110-351; hereinafter termed "Fostering Connections Act" or the "Act"). Specifically, the Act is designed to increase the role of kinship caregivers,[5] incentivize adoption and provide ongoing supports for youth transitioning out of foster care.

**Mandatory Provisions**

The Fostering Connections Act includes both mandatory and optional provisions for states. All states must comply with the Act's mandatory provisions, which include:

- providing all adult relatives written notice regarding a child's removal from the home and support options available to relatives (including how to become a foster parent);[6]
- reauthorizing the adoption incentive program for an additional five years through 2013;[7]
- gradually eliminating income related tests for Title IV-E[8] adoption assistance eligibility;
- making reasonable efforts to place siblings together or to have frequent visitation or other ongoing interaction between siblings if placed separately;
- making efforts to ensure educational stability for children in foster care;
- requiring a Child Protective Services (CPS) caseworker to provide transition planning within 90 days of a youth aging out of foster care;
- providing oversight and coordination of health care for youth in foster care;
- informing any individual who is adopting that they may be eligible for a federal adoption tax credit; and
- reporting on certain data related to relatives becoming foster parents.

**Optional Provisions**
The Fostering Connections Act also includes a number of optional provisions that the Texas Legislature enacted during the 81st legislative session.[9] These include:

- establishing a relative guardianship assistance program (termed the "new Kinship Care program" in Interim Charge; hereinafter termed "Permanency Care Assistance," or "PCA" program) for relatives who take legal custody of a foster child and serve as the child's foster parents for six consecutive months;
- providing payments for adoption assistance or Permanency Care Assistance up to age 21 if the agreement is signed after the child's 16th birthday and the child is engaged in certain educational or vocational activities; and
- providing additional extended foster care options and Title IV-E foster care benefits from age 18 to 21 if the youth is engaged in certain educational or vocational activities.

This report focuses on the PCA program and recommendations to optimize the use of financial assistance to qualified kinship caregivers.

# Analysis

**Overview of Placement Options with a Kinship Caregiver**
Kinship caregivers interested in caring for a child removed from the home due to abuse or neglect have a number of options. For example, the child may be placed with a kinship caregiver under the Relative and Other Designated Caregiver Assistance Program (hereinafter termed "Relative Caregiver Assistance Program"), or the Foster Care Program. In addition, if a court determines reunification is not an appropriate permanency option, the child may be adopted or placed with a kinship caregiver under the PCA program.[10] Table 1 includes additional information about each of these placement options (listed in order of priority). Each placement option is also discussed in further detail throughout this report.

**Table 1. Placement Options with a Kinship Caregiver[11]**

| Program | Requirements | Maximum Monthly Financial Assistance | Additional Benefits |
|---|---|---|---|
| **Relative Adoption** | Court must terminate biological parents' rights and grant adoptive parent(s) the same legal standing as a birth family. | **Basic care:** $400<br>**Moderate to Intense care:** $545 | • Post-adoption services[12]<br>• Medicaid<br>• Non recurring reimbursement up to $1,500 per child[13]<br>• Extended payments up to child's 21st birthday under certain circumstances[14] |
| **PCA Program** | Court must grant caregiver custody of the child. Biological parents' rights may or may not be terminated. | **Basic care:** $400<br>**Moderate to Intense care:** $545 | • Medicaid (or equivalent)<br>• Reimbursement up to $2,000 for legal fees incurred while obtaining custody of the child.<br>• Extended payments up to child's 21st birthday under certain circumstances[15] |
| **Relative Foster Care** | Caregiver must maintain foster home certification. CPS and court cases remain open. Monthly caseworker visits and periodic court hearings continue. | **Basic care:** $664<br>**Moderate care:** $1,163<br>**Specialized care:** $1,495<br>**Intense care:** $2,659 | • May be eligible for day care<br>• Access to Star Health while Department of Family and Protective Services (DFPS) has custody of the child<br>• Extended payments up to child's 21st birthday under certain circumstances[16] |
| **Relative Caregiver Assistance Program** | CPS and court cases remain open. Monthly caseworker visits and periodic court hearings continue. | Onetime payment of $1,000. No monthly financial assistance. | • May be eligible for day care<br>• Up to $500 per child per year (for up to three years) for child related expenses, if caregiver takes custody of the child<br>• Star Health (if DFPS has custody)or may be eligible for Medicaid through TANF[17] (if caregiver has custody) |

## PCA Program Overview

The PCA program is a new permanency option targeted to children who cannot safely return home and are not eligible for adoption. These children would otherwise grow up in the child welfare system and age out of foster care never achieving true permanency. Table 2 includes the number of Texas children who aged out of foster care from fiscal years (FY) 2005-2009, illustrating a general upward trend.

**Table 2. Texas Children who Aged out of Foster Care[18]**

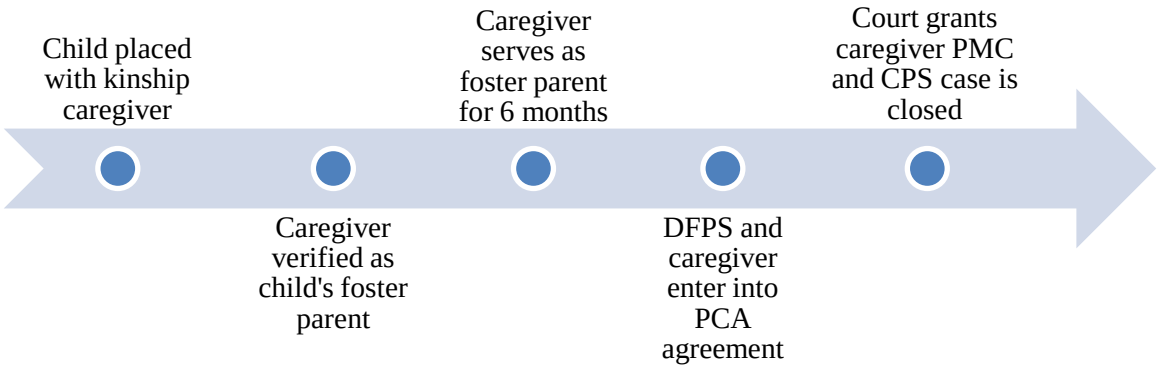
| Fiscal Year | Number of Children who Aged Out of Foster Care | Increase/Decrease from Prior Year |
|---|---|---|
| 2005 | 1,139 | N/A |
| 2006 | 1,328 | 16.59% |
| 2007 | 1,377 | 3.69% |
| 2008 | 1,434 | 4.14% |
| 2009 | 1,431 | -0.21% |

In addition to providing children a new permanency option, the PCA program is intended to stem the anticipated increase in foster care providers owing to the Fostering Connections Act's mandatory relative notification requirement. The Act requires states to notify all adult relatives of a child's removal from the home and support options available to relatives, including how to become a foster parent. Foster care is easily the most expensive support option available to relatives and until recently, the Department of Family and Protective Services (DFPS) did not advertise foster care as a support option for relatives. Although it is too soon to gauge the impact of this federal mandatory relative notification requirement, the number of relative foster care providers is expected to increase substantially. The PCA program is intended to temper this growth by encouraging relative foster care providers to exit paid foster care and enter the less costly PCA program. Although kinship caregivers receive far smaller subsidies under the PCA program than in foster care, caregivers may prefer this option, as it provides children (and caregivers) permanency, unlike foster care.

Under the PCA program, DFPS provides financial assistance to kinship caregivers who agree to take legal custody of a child in DFPS' care for whom reunification and adoption have been ruled out as permanency options. Caregivers interested in participating in the program must become verified foster parents, serve as the child's foster parent for at least six months, then enter into a PCA agreement with DFPS. After the caregiver serves as the child's foster parent for at least six months, the court may grant the caregiver legal custody of the child (hereinafter termed "permanent managing conservatorship" or "PMC"), at which time the child's CPS case will be closed.[19]

In most cases, a PCA agreement remains in effect until the child turns 18 years old.[20] Figure 1 illustrates this process. Unlike children in foster care, who remain in DFPS' PMC, children in the PCA program achieve permanency once the kinship caregiver becomes the child's permanent managing conservator. CPS caseworker visits and court appointments are discontinued and from the child's perspective, he/she can finally settle into a "normal" life.

**Figure 1. Steps to Achieving Permanency Under the PCA Program**




As of June 2010, DFPS identified almost 3,400 children currently in foster care who would likely benefit from the PCA program.[21] DFPS began entering into PCA agreements in September 2010 and distributing payments to participating kinship caregivers in October 2010. At the time of this writing, 42 kinship caregivers have become verified foster parents (of 95

children) with the goal of participating in the PCA program after serving as the child's foster parent for six months.[22]

**Financial Considerations**

Before becoming a verified foster parent and participating in the PCA program, kinship caregivers who accept placement of a child through the Relative Caregiver Assistance Program may receive a onetime integration payment of $1,000.[23] Once the caregiver becomes a verified foster parent, he/she will begin receiving monthly foster care reimbursement payments. Depending on the child's needs, these payments may range from $664 per child (for basic care) to over $2,600 per child (for intense care). After serving as the child's foster parent for six months, a caregiver granted PMC of the child and enrolled in the PCA program will no longer receive monthly foster care reimbursement payments. Instead, the caregiver will begin receiving monthly PCA assistance payments, up to $400 per child (for basic care) or up to $545 per child (for moderate to intense care). In addition, caregivers may be reimbursed up to $2,000 for certain expenses incurred while obtaining PMC of the child (e.g., attorney's fees, court costs).[24]

Assuming the PCA program operates as intended by successfully diverting children who would otherwise age out of foster care and providing them a new permanency option, the PCA program may achieve long term cost savings. These savings can be attributed to a number of factors, including reducing the amount of time children remain in foster care (and associated foster care subsidies which are considerably higher than PCA program subsidies) and closing the CPS case, thereby alleviating caseworkers' caseloads and courts' overcrowded dockets, in addition to avoiding administrative costs and counties' attorney ad litem costs.[25] Table 3 illustrates the potential cost savings associated with the PCA program as compared to foster care over a 5.3 year period (the average length of time a child spends in foster care[26]). This table does not include cost avoidance estimates associated with closing the CPS case earlier under the PCA program.

**Table 3. Potential Cost Savings in PCA Program[27]**

| Average Placement Cost Per Child | | | |
|---|---|---|---|
| **Year** | **Foster Care** | **PCA Program** | **Cost Avoidance** |
| **1** | $21,593 | $15,548 | $6,045 |
| 2-5.3 | $92,312 | $23,524 | $68,788 |
| **Totals** | **$113,905** | **$39,072** | **$74,833** |

**Potential Challenges**

DFPS is taking a number of precautions to ensure that the PCA program operates as intended, including identifying children who would benefit from the program, conducting outreach to kinship caregivers and hosting information sessions. Notwithstanding these efforts, the state's implementation of the Fostering Connections Act and the PCA program may result in the following inadvertent and potentially costly consequences:

1. far more kinship caregivers will become verified foster parents as a result of the Fostering Connections Act's mandatory relative notification requirement, and some may remain in paid foster care long term;
2. the PCA program may discourage some kinship caregivers from adoption; and
3. kinship caregivers may encounter barriers to becoming a verified foster parent, rendering them unable to participate in the PCA program.

*1. More Caregivers will Become Verified Foster Parents and Remain in Foster Care Long Term*

The number of kinship caregivers who will now become verified foster parents will undoubtedly increase. If these foster parents do not quickly and successfully move into the PCA program, we will likely see considerable increases in caseworker caseloads, court dockets, and the need for Court Appointed Special Advocate (CASA) volunteers, as well as an enormous financial strain on DFPS' Child Protective Services budget.

Before the Fostering Connections Act was enacted, the Relative Caregiver Assistance Program was the only support option available to a relative seeking to care for a child who could not safely return home and was not eligible for adoption. Very few kinship caregivers became verified foster parents,[28] due in large part to DFPS not advertising relative foster care as a support option. In light of the new federal requirement that states must notify all adult relatives of support options available to them, including becoming a verified foster parent, the number of relatives who will become verified foster parents (irrespective of the PCA program) will undoubtedly increase.

A. Impact of Increase in Number of Verified Foster Parents

For children who would have been placed in foster care anyway, this increase is both beneficial and cost neutral. Research indicates that relatives are better able to reinforce the child's sense of cultural identity and positive self esteem, maintain connections with extended family, continue family traditions and provide a sense of stability in the child's life, compared to non-relatives.[29] In addition, because relative foster parents are paid the same as non relative foster parents, an increase in the number of relative foster parents caring for children who would have been placed in foster care anyway would have no financial impact.

However, the financial impact will be substantial if kinship caregivers who would have otherwise taken PMC of a child with little or no financial assistance now choose to become verified foster parents and either transfer into the PCA program or continue providing foster care long term. As illustrated in Table 1, costs associated with both of these support options far outweigh the costs of a caregiver taking PMC of a child under the Relative Caregiver Assistance Program or providing care for free. In fiscal year 2010, almost 1,000 kinship caregivers took PMC of children with no financial assistance from DFPS.[30] If only 25% of these caregivers had participated in the PCA program, the resulting cost would be almost $1.6 million in Year 1 and $1.2 million for each subsequent year.[31]

B. Reasons Caregivers May Remain in Foster Care Long Term

A number of child welfare advocates believe the prospect of a child achieving permanency will compel kinship caregivers to quickly exit foster care and move into the PCA program. However, caregivers must also be willing and able to receive a substantially reduced monthly payment in order to make this transition. Caregivers with low to moderate incomes may remain in foster care simply because they cannot afford to care for the child for a reduced payment. For example, for a child requiring basic care, moving from foster care into the PCA program would result in a reduction in reimbursement of almost $3,200 per year, along with day care subsidies and STAR Health[32] insurance coverage for the child. For a child requiring moderate to intense care, the reduction in reimbursement would be staggering, at between $7,400 and $25,400 per year.

Even caregivers with higher incomes may remain in foster care long term. Unlike foster care reimbursement rates, which are uniform, monthly payments under the PCA program vary depending on the caregiver's income. Caregivers with higher incomes will receive lower PCA payments, resulting in an even wider gap between the caregiver's monthly foster care payment and his/her monthly payment after transferring to the PCA program.[33]

A federal review of other states' permanency programs concluded that for many kinship caregivers, financial considerations ultimately outweigh other benefits associated with achieving permanency, as a number of caregivers were reluctant to absorb the financial loss after exiting paid foster care and assuming PMC of the child.[34] Some child welfare advocates believe increasing PCA subsidies will incentivize kinship caregivers to exit foster care and participate in the PCA program. However, federal law prohibits states from setting PCA payments higher than foster care payments. Even making PCA and foster care payments equal would be very costly and would likely discourage adoption, as discussed in the next section.

Notwithstanding these concerns, data suggest kinship caregivers often forego higher foster care subsidies in favor of helping the children in their care achieve permanency. Although it is too soon to determine the percent of caregivers who will exit foster care and participate in the PCA program, data concerning relative foster parents who ultimately adopt is instructive. As indicated in Table 4, approximately 48% of children in relative foster care are ultimately adopted by their foster parents. This data is promising, considering that adoption subsidies and PCA subsidies are equal. Caregivers who exit foster care to adopt the child stand to lose just as much as caregivers who exit foster care to participate in the PCA program. Yet almost half of these caregivers voluntarily exit foster care in order to adopt the child.

**Table 4. Texas Children Ultimately Adopted by Relative Foster Parents**

| Fiscal Year | Number of Children Placed with Relative Foster Parents | Number of Children Adopted by Relative Foster Parents | Percent of Children Adopted by Relative Foster Parents |
|---|---|---|---|
| 2007 | 116 | 67 | 57.8% |
| 2008 | 107 | 46 | 43% |
| 2009 | 89 | 39 | 43.8% |

C. State's Efforts to Mitigate Concerns

DFPS has implemented a number of procedures to ensure kinship caregivers quickly transition into the PCA program. For example, once a caregiver becomes a child's foster parent, DFPS will document that the placement is intended to help the child achieve permanency. In addition, once reunification and adoption are ruled out and PMC with the caregiver becomes the child's permanency plan, DFPS will direct the caregiver to execute a Statement of Intent to Pursue PCA. DFPS has also taken a number of actions to increase caregivers' awareness of the PCA program, including sending letters introducing caregivers to the PCA program; encouraging staff and community partners to share information about the program with interested parties; and establishing a dedicated email address and website to answer caregivers' questions about the program.

*2. The PCA Program May Discourage Kinship Caregivers from Adoption*

Both kinship caregivers who adopt a child and those who accept PMC of the child under the PCA program help the child achieve permanency. However, accepting PMC of a child has far fewer legal consequences than adoption. Unlike adoption, a permanency option that requires a court to terminate the biological parents' rights and grant the child's adoptive parents the same legal standing as a birth family,[35] participation in the PCA program does not require a court to terminate parental rights. In this case, the caregiver obtains legal custody of the child, but the biological parents' rights may remain intact. Once the child turns 18, the court's jurisdiction and the caregiver's PMC end, at which time the child's relationship with the caregiver becomes strictly voluntary.[36]

A. Reasons Caregivers May Choose the PCA Program Over Adoption

Despite the substantial legal differences between these two permanency options, their monthly subsidies are the same, eliminating any financial incentive to adopt. This means a kinship caregiver would receive the same amount each month irrespective of which permanency option he/she pursued. Considering the lifelong consequences associated with adoption and the lack of any financial incentive to adopt, caregivers may be more inclined to participate in the PCA program rather than risk upsetting already unstable family dynamics by adopting a relative's child. For example, a child's aunt may be reluctant to adopt her sister's child due to the lifelong impact forced termination of parental rights would have on their sibling relationship (as well as on the relationship between the sister and her own child). However, the aunt may be willing to take custody of the child under the PCA program.

Some child welfare advocates recommend reducing the PCA program subsidy in order to incentivize adoption. While reducing the PCA subsidy may encourage some caregivers to adopt, it may also inadvertently funnel even more caregivers into long term foster care (rather than the PCA program), because reducing the PCA subsidy would further widen the reimbursement gap between foster care and the PCA program. For example, a caregiver with limited income may be reluctant to adopt but may want to pursue a support option that provides the child with a sense of permanency. If the caregiver's only options are minimal benefits under the Relative Caregiver Assistance Program, a reduced subsidy under the PCA program, and foster care, the caregiver may choose foster care simply because he/she cannot otherwise afford to care for the child. This outcome is far from ideal, as foster care is the most expensive support option and does not provide the child with a sense of permanency.

B. Potential Loss of Federal Adoption Incentive Funds

It is too soon to determine whether the PCA program will discourage kinship caregivers from adoption. However, if it does, Texas may risk losing federal funding. Since 1999, Texas has received federal adoption incentive funds for exceeding certain benchmarks relating to adoptions of foster children (e.g., adoptions of older children or children with disabilities). From federal fiscal year 2006 through 2009, Texas received funds in excess of $14 million. As Table 5 indicates, the number of completed adoptions has increased substantially each year, due in part to an increase in relative adoptions.[37] However, if this number begins to decline, Texas may no longer receive these needed funds.

**Table 5. Adoptions of Foster Children in Texas[38]**

| Fiscal Year | Number of Adoptions |
|---|---|
| 2005 | 3,173 |
| 2006 | 3,376 |
| 2007 | 4,023 |
| 2008 | 4,517 |
| 2009 | 4,859 |

Even if the PCA program does not result in fewer adoptions, DFPS expects the number of completed adoptions will soon plateau, placing federal adoption incentive funds at risk. Although the Fostering Connections Act reauthorized the adoption incentive program for an additional five years through 2013, DFPS anticipates that Texas will only receive adoption incentive funds through FY 2011.

C. State's Efforts to Mitigate Concerns

In order to ensure that the PCA program does not discourage kinship caregivers from adopting, the Fostering Connections Act directs states to target the PCA program only to children whom a court has determined cannot safely return home and are not eligible for adoption (hereinafter termed the "adoption rule out provision").[39] There are a number of reasons a child may not be eligible for adoption, including:

- the child is not available for adoption because the court did not terminate parental rights;
- the child is of a mature age and does not want to be adopted; or
- the child's medical and/or behavioral health needs are so intense that the child cannot be adopted.

In addition to the adoption rule out provision, DFPS policy requires CPS caseworkers to consider PMC by a relative only after reunification with the child's biological parent(s) and relative adoption are ruled out.[40] This is intended to prevent caseworkers from prematurely ruling out reunification or adoption in order to avoid inconveniencing the parties involved. As an additional precaution, DFPS policy now requires a supervisor's approval of any decision to rule out adoption and place a child in the PCA program. Courts also provide some oversight by ensuring DFPS properly determined reunification and adoption are not appropriate permanency options for the child before the court can grant the caregiver PMC of the child.

*3. Kinship Caregivers may Encounter Barriers to Becoming a Verified Foster Parent*

Unlike kinship caregivers who participate in the Relative Caregiver Assistance Program, caregivers interested in becoming a child's foster parent must first satisfy a number of requirements, all of which are prerequisites to participating in the PCA program. Caregivers with low to moderate incomes may lack the financial resources to comply with these requirements.

For example, among other requirements, prospective foster parents must have adequate sleeping space, obtain fire, health and safety inspections of the home, vaccinate all pets, obtain and maintain CPR and first aid certifications, and obtain tuberculosis testing for household members. The Fostering Connections Act authorizes states to waive certain non-safety related requirements on a case by case basis, as determined by the state. However, the only waivable non-safety requirement among those previously mentioned is the requirement for caregivers to have

adequate sleeping space. Caregivers who wish to become a child's foster parent remain obligated to pay for CPR and first aid certification, health and fire inspections, pet vaccinations and tuberculosis testing.

A. State's Efforts to Mitigate Concerns

In order to alleviate the financial burden of becoming a verified foster parent, DFPS encourages kinship caregivers participating in the Relative Caregiver Assistance Program to apply a portion of their $1,000 integration payment toward satisfying these requirements. However, some caregivers may have competing needs for the payment (e.g., a bed and/or clothing for the child). In light of these financial constraints, DFPS is also working with community partners to arrange for private donations and financial assistance for caregivers.

**Other Considerations**

*Children Placed in DFPS' PMC without Terminating Parental Rights*

Child welfare advocates are concerned that a number of children cannot be adopted because they are inappropriately placed in DFPS' PMC without a court first terminating the biological parents' rights. Instead of being adopted and achieving permanency, these children may remain in long term foster care until finally aging out at 18 or 21 years old.

Under Texas law, a court may grant DFPS PMC of a child without terminating parental rights if granting PMC to the child's parent, a relative, or another person would not be in the child's best interest.[41] Circumstances under which a court may grant DFPS PMC of a child without terminating parental rights may include:

- The parent is unable to meet the child's needs; however, the parent and child are attached.
- The non-abusive parent is unable to provide a safe environment for the child to return to.
- An older child would benefit more from remaining in DFPS' care and receiving Transitional Living Services,[42] rather than be returned to his/her parent(s) or relative(s).
- Evidence may not be compelling enough to support termination of parental rights.
- The court, attorney ad litem, CASA volunteer and/or CPS caseworker may believe the child has intense needs and is not likely to be adopted.
- The parent may have a disability preventing him/her from caring for the child full time.
- A foster parent expressed commitment to the child but is unwilling to adopt.

In determining whether to grant DFPS PMC of the child without terminating parental rights, the court must consider the following factors:

- that the child will reach 18 years of age in not less than three years;
- that the child is 12 years of age or older and has expressed a strong desire against termination of parental rights or being adopted;
- that the child has special medical or behavioral needs that make adoption of the child unlikely; and
- the needs and desires of the child.[43]

As of March 2010, almost 4,000 children were in DFPS' PMC without termination of parental rights.[44] Of these, over 450 are under age six and 114 are under age three.

In order to minimize the number of children in DFPS' PMC without termination of parental rights, DFPS could petition the court to have children placed in DFPS' PMC only if parental rights are terminated. However, this may not be feasible in all cases. For example, a court may determine this is not in the child's best interest or that there are not sufficient grounds to terminate parental rights. In addition, federal regulations require states to provide a full range of permanency options for children in the child welfare system, including PMC without termination of parental rights.

DFPS is attempting to reduce the number of children placed in DFPS' PMC without termination of parental rights by:

- encouraging kinship caregivers to take PMC of the child under the PCA program;
- focusing on children under age 10 who are in DFPS' PMC without termination of parental rights (regardless of placement type); and
- amending DFPS policy to require regional leadership approval before DFPS can agree to PMC without termination of parental rights.

*Mediated Settlements*

A court may grant DFPS PMC without termination of parental rights in accordance with a mediated settlement agreement. Under Texas law, parties to a suit affecting the parent-child relationship (e.g., DFPS, child's biological parent) may enter into mediation and negotiate a settlement agreement.[45] Attorneys representing DFPS and the child may choose to enter into mediation due to insufficient evidence to support termination of parental rights. Mediated settlement agreements are not subject to judicial review in all cases. Instead, a court may decline to enter a judgment on a mediated settlement agreement only if the court finds (1) a party to the agreement was a victim of family violence and that circumstance impaired the party's ability to make decisions (e.g., victim agreed to settlement agreement under duress or as a result of intimidation by abuser), and (2) the agreement is not in the child's best interest.[46] In order to ensure that mediated settlements are only pursued when necessary and in the child's best interest, Texas law should be amended to authorize courts to reject any mediated settlement agreement that is not in the child's best interest.

In October 2010, DFPS initiated a workgroup to evaluate the impact of mediation on the increasing number of very young children entering into DFPS' PMC without termination of parental rights.[47] DFPS is developing policy that will require regional leadership approval before CPS staff can agree to a mediated settlement involving a child under age 10 in which PMC to DFPS is granted without termination of parental rights.[48] The workgroup is addressing logistical and process issues as well as staff training regarding the use of mediation as a tool to successfully achieve permanency.[49]

# Conclusion

The Fostering Connections Act provides children in the child welfare system a new permanency option with the goal of improving outcomes for children who would otherwise age out of foster care. In addition, the Act promotes family connections, provides ongoing supports for older youth transitioning out of foster care, and promotes health and education. In light of this new permanency option, children who would otherwise be relegated to a life in foster care can now settle into a normal life with a "forever" home. Although the Act goes a long way toward

promoting permanency and increasing the role of kinship caregivers, the federal mandatory relative notification requirement may lead to a surge in the number of verified foster care providers and foster care subsidies in Texas. Although the PCA program is intended to mitigate these increased costs, it too may have unintended and costly consequences, depending on how it is implemented.

# Recommendations

1. **Direct the Department of Family and Protective Services to apply for a waiver allowing the department to reduce benefits to kinship caregivers who remain in paid foster care long term.**

   Currently, DFPS cannot compel kinship caregivers to enter the PCA program after serving as the child's foster parent for six months. As a result, kinship caregivers who choose not to enter the PCA program will continue receiving the higher foster care subsidy and the children in their care will not achieve permanency. This recommendation is intended to incentivize relatives to exit the foster care system and enter the PCA program, which is less costly than foster care and certain to provide the child with a sense of permanency.

---

[1] Foster care is intended to function as a temporary placement for children removed from their homes due to abuse or neglect and there is not an appropriate relative or close family friend to care for them. See "What is Foster Care" available online at http://www.dfps.state.tx.us/Child_Protection/Foster_Care/ (last accessed June 17, 2010).

[2] Generally, youth age out of foster care at age 18. However, Texas youth may remain in foster care until age 19 or 20, if they satisfy certain vocational or educational requirements, respectively. *Texas Foster Care Handbook for Youth*, Department of Family and Protective Services (DFPS), p. 12. Available online at http://www.dfps.state.tx.us/Documents/Child_Protection/pdf/foster-care-handbook.pdf (last accessed June 17, 2010).

[3] "Improving Outcomes for Older Youth in Foster Care," Casey Family Programs, pp. 3-4. 2008. Available online at http://www.casey.org/Resources/Publications/pdf/WhitePaper_ImprovingOutcomesOlderYouth_FR.pdf (last accessed June 17, 2010). *See also* "Study Finds More Woes Following Foster Care," New York Times, April 6, 2010. Available online at http://www.nytimes.com/2010/04/07/us/07foster.html (Last accessed July 30, 2010).

[4] In this context, permanency means children are permanently placed with relative(s) or adopted and DFPS' legal responsibility has terminated. DFPS Annual Report and Data Book 2009, p. 63. Available online at http://www.dfps.state.tx.us/About/Data_Books_and_Annual_Reports/2009/default.asp (Last accessed August 2, 2010) (hereinafter termed "DFPS Data Book 2009").

[5] Kinship caregivers include relatives, close family friends and others having a longstanding relationship with the child. See "Kinship Care Manual for Caregivers" available online at http://www.dfps.state.tx.us/Child_Protection/Kinship_Care/ (last accessed July 7, 2010).

[6] Prior to the Fostering Connections Act, DFPS did not inform prospective kinship caregivers of the option to become a foster parent and only a small number of kinship caregivers became verified foster parents.

[7] The federal adoption incentive program is authorized through 2013. According to DFPS, Texas expects to receive adoption incentive funds for fiscal years 2010 and 2011. However, in the near future, Texas will likely reach a plateau in the numbers of consummated adoptions and will not continue to receive adoption incentive funds. See page 8 of this report for additional information.

[8] Title IV-E of the Social Security Act (42 United States Code §670 et seq.) is a federal foster care program which, among other things, assists states with the cost of care for children who qualify for financial assistance will likely reach a plateau in the numbers of consummated adoptions and will not continue to receive adoption incentive funds.

[8] Title IV-E of the Social Security Act (42 United States Code §670 et seq.) is a federal foster care program through the Aid to Families with Dependent Children Program, and who meet the eligibility requirements described in 42 USC §672(a). See Tex Admin. Code §347.3(18).
[9] HB 1151 (Thompson/West); SB 2080 (Uresti/McClendon; coauthored by Senators Nelson and Patrick).
[10] In addition, if a court determines reunification and adoption are not appropriate permanency options, the court may grant a kinship caregiver participating in the Relative Caregiver Assistance Program legal custody of the child.
[11] Table 1 prepared using information provided by DFPS.
[12] Post-adoption services include information and referral; casework services and service planning; parent groups; parenting programs; counseling services; respite care; residential placement services in critical need situations; and crisis intervention. Availability of services is dependent on funding and the individual child and family situation. *See* https://www.dfps.state.tx.us/Child_Protection/Adoption/assist.asp#postadopt (Last accessed September 9, 2010).
[13] These non recurring expenses include adoption fees, court costs, attorney fees and other expenses directly related to the legal completion of the adoption.
[14] Assistance payments continue until the child turns 21 if child was 16 or older when the adoption agreement was executed and the child is engaged in certain educational or vocational activities, including attendance at an institution of higher learning; participation in a program/activity that promotes or removes barriers to employment; employment for at least 80 hours per month; or the child is incapable of doing any of the allowed activities described in Texas Family Code Sec. 264.101(a)(1) due to a documented medical condition.
[15] Assistance payments continue until the child turns 21 if child was 16 or older when the PCA agreement was executed and the child is engaged in certain educational or vocational activities or the child is incapable of doing any of the allowed activities described in Texas Family Code Sec. 264.101(a)(1) due to a documented medical condition.
[16] Foster care benefits can be extended for youth ages 18-21 who are engaged in certain educational or vocational activities or the child is incapable of doing any of the allowed activities described in Texas Family Code Sec. 264.101(a)(1) due to a documented medical condition.
[17] Temporary Assistance for Needy Families (TANF) provides financial help for children and their parents or relatives who are living with them. Monthly cash payments help pay for food, clothing, housing, utilities, furniture, transportation, telephone, laundry, household equipment, medical supplies not paid for by Medicaid and other basic needs. The amount of the TANF payment depends on family size and income. For additional information, see "Temporary Assistance for Needy Families" available online at http://www.hhsc.state.tx.us/help/financial/temporary_assistance.html (last accessed October 21, 2010).
[18] Table 2 prepared by DFPS.
[19] The prospect of a PCA agreement should not delay the progress of a case toward final orders and permanency for the child. Although the Fostering Connections Act requires relatives to serve as a child's verified foster parents for six months before being eligible for the PCA program, after the six month period, it should take no more than 30 days to place the child in the PCA program.
[20] Tex. Admin. Code §700.1047. The child and family may be eligible for extended permanency care assistance after age 18 under certain circumstances. See Tex. Admin. Code §700.1053.
[21] Data provided by DFPS via email dated August 9, 2010. According to DFPS, ideal groups for the PCA program include children in kinship placements who are in DFPS' PMC and children in DFPS' temporary managing conservatorship whose permanency goal is PMC with a kinship caregiver.
[22] Data provided by DFPS via email dated October 6, 2010.
[23] In order to be eligible for financial assistance under the Relative Caregiver Assistance Program, the caregiver's family income must not exceed 300 percent of the Federal Poverty Level. Financial benefits associated with the Relative Caregiver Assistance Program are General Revenue funds and are available for eligible relatives, close family friends and others having a longstanding relationship with the child.
[24] The $2,000 reimbursement is federally mandated for states that choose to establish a PCA program.
[25] DFPS Presentation to Senate Health and Human Services Committee, March 10, 2010, slide 5 (hereinafter termed "DFPS Senate HHS Presentation"). Available online at http://www.dfps.state.tx.us/documents/about/Presentations/2010-03-10_Senate_Charge_14.pdf (Last accessed August 2, 2010).
[26] See Texas DFPS Data Book 2009, p. 61.
[27] Table prepared by DFPS.
[28] DFPS Senate HHS Presentation, slide 10.

[29] DFPS, Progress Report: Relative and Other Designated Caregiver Assistance Program, December 2009, p. 5. Available online at http://www.dfps.state.tx.us/documents/Child_Protection/pdf/2009-12-01_Progress-Report.pdf (Last accessed August 4, 2010).
[30] Data provided by DFPS via email dated October 6, 2010.
[31] Calculation assumes that in Year 1, each caregiver would receive $674 per month for six months as a verified foster parent, then $400 per month for six months under the PCA program.
[32] For additional information regarding the STAR Health managed care system, see the Charge #13 interim report.
[33] Caregivers may appeal the DFPS negotiator's determination.
[34] U.S. Department of Health and Human Services Administration for Children and Families, http://www.acf.hhs.gov/programs/cb/programs_fund/cwwaiver/agissue/evaluation.htm#process (Last accessed August 2, 2010).
[35] Tex. Fam. Code §162.017. *See also* " Adoption or Permanent Managing Conservatorship," DFPS. Available online at http://www.dfps.state.tx.us/child_protection/adoption/pmc.asp (Last accessed August 5, 2010).
[36] CPS Handbook, Sec. 6221.42. Available online at http://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_6221_4.jsp#CPS_6221_42 (Last accessed September 9, 2010).
[37] See Texas DFPS Annual Report and Data Book 2009, p. 6.
[38] Table prepared by DFPS.
[39] The Fostering Connections Act also requires a child's case plan to include steps taken to determine that reunification and adoption are not appropriate permanency options.
[40] CPS Handbook, Sec. 6221.1. Available online at http://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_6221.jsp#CPS_6221_1 (Last accessed August 10, 2010).
[41] Texas Family Code §263.404(a).
[42] Among other services, Transitional Living Services include Preparation for Adult Living programs; the Education and Training Voucher program; and formal transition planning. *See* "Transitional Living Services", Department of Family and Protective Services. Available online at http://www.dfps.state.tx.us/child_protection/transitional_living/ (Last accessed August 11, 2010).
[43] *Id.* at §263.404(b).
[44] Data provided by DFPS via email dated March 26, 2010.
[45] Tex. Fam. Code §153.0071(d).
[46] Tex. Fam. Code §153.0071(e-1).
[47] Information received from DFPS via email dated October 28, 2010.
[48] *Id.*
[49] *Id.*

Interim Charge #14B: *Monitor the implementation of legislation addressed by the Senate Committee on Health & Human Services, 81st Legislature, Regular and Called Sessions, and make recommendations for any legislation needed to improve, enhance, and/or complete implementation.*

- *Monitor the Department of Aging and Disability Services(DADS) implementation of SB 643, relating to Texas' state supported living centers (SSLCs), implementation of Special Provisions relating to All Health and Human Services Agencies, Section 48. Contingency Appropriation for the Reshaping of the System for Providing Services to Individuals with Developmental Disabilities, and implementation of the United States Department of Justice (DOJ) Settlement Agreement terms.*

# Background

In March 2005, the U.S. Department of Justice (DOJ) began investigating Texas' state supported living centers (hereinafter referred to as "SSLCs" or "centers," formerly termed "state schools") following reports of widespread abuse, neglect and even residents' deaths. In December 2008, the DOJ issued its findings, including serious deficiencies due to failure to protect residents from harm; inadequate medical and behavioral health services; improper use of restraints; and failure to provide services in the most integrated setting appropriate to residents' needs.[1] The Department of Aging and Disability Services (DADS) implemented a corrective action plan and in May 2009, Texas and the DOJ entered into a five year settlement agreement. The settlement agreement requires independent monitors, enhanced efforts to detect and deter abuse, and improvements to the level of care for Texans with intellectual and developmental disabilities.

In addition to the DOJ settlement agreement, the 81st Legislature implemented a number of sweeping reforms concerning Texas' SSLCs and services for individuals with intellectual and developmental disabilities. These reforms include Senate Bill 643 (Nelson/Rose) and the 2010-11 General Appropriations Act (Article II, Special Provisions, Section 48, Senate Bill 1, 81st Legislature, Regular Session, 2009) (hereinafter referred to as "Rider 48").

# Analysis

**Implementation of SB 643**

In Texas, SSLCs are included in the array of services available to individuals with intellectual and developmental disabilities.[2] Texas' 13 SSLCs are operated by DADS and provide around the clock residential services, treatment and healthcare for individuals with intellectual and developmental disabilities who are medically fragile or who have behavioral problems.[3] SSLC residents have varying disabilities and functional levels, ranging from mild to profound. A number of residents have medically complex issues or profound behavioral health issues, requiring assistance at mealtimes and frequent monitoring, while others are relatively independent and require minimal assistance. As of August 2010, 4,207 individuals resided at a SSLC. Figure 1 includes a map of Texas' 13 SSLCs.

**Figure 1. Texas State Supported Living Centers[4]**


*SB 643 Major Provisions*

SB 643 included a number of procedural reforms designed to strengthen the oversight of Texas' SSLCs, improve the quality of care delivered in these facilities and ensure the protection of Texans with intellectual and developmental disabilities. These reforms include:

Video Surveillance

SB 643 required video surveillance cameras to be installed in common areas (e.g., living rooms, dining rooms, hallways, active treatment centers) of each SSLC. In addition to deterring SSLC staff and residents from committing an act of abuse or neglect, these cameras are intended to help investigators quickly dismiss any false reports of abuse or neglect. Once completed, over 3,200 cameras will be installed in 335 buildings throughout Texas' SSLCs. In November 2009, installation of video surveillance cameras began and as of November 2010, this project was almost 75% complete, with cameras operational at Corpus Christi, Mexia, San Angelo, Denton, El Paso, San Antonio, Abilene, Lubbock and Lufkin SSLCs.[5] Camera installation in the remaining four centers (Richmond, Austin, Brenham and Rio Grande) should be completed by January 2011.[6]

FBI Fingerprint Based Criminal Background Checks

SB 643 required FBI fingerprint checks of all SSLC employees and volunteers who have direct contact with any resident. In September 2009, DADS began fingerprinting applicants upon hiring and in December 2009, DADS completed fingerprinting of all current employees and volunteers. As a result of these fingerprint checks, DADS disqualified 244 applicants from employment and identified 36 employees with criminal records barring them from employment.[7] Of these, 29 employees were terminated and seven provided documentation indicating that the

charges were dropped or that there was no record of a conviction. Fingerprinting will continue as new employees are hired and new volunteers begin service.[8]

Random Drug Testing

SB 643 required random drug testing of SSLC employees. Statewide testing began in October 2009 and each month, 2.1 percent of SSLC employees are randomly selected and tested. As of August 2010, 3,026 employees have been tested. Of these, 58 tested positive for a controlled substance and were terminated and nine resigned in lieu of testing.[9]

Office of Independent Ombudsman

SB 643 established an Office of Independent Ombudsman to act as a confidential intermediary between residents, their family members or legally authorized representatives and DADS and to ensure that residents' rights are protected. In February 2010, Governor Rick Perry appointed Dr. George Bithos as the Independent Ombudsman for SSLCs for a term to expire June 11, 2011.[10] Dr. Bithos hired assistant ombudsmen who are stationed at each SSLC. The assistant ombudsmen assist residents, family members, residents' legally authorized representatives, staff, and others having concerns about the centers. A majority of the concerns received by the Office of Independent Ombudsman originated from SSLC staff and residents and involved rights issues and service delivery.[11] However, the Ombudsman has also received concerns regarding abuse, neglect and exploitation,[12] staffing, guardianship and discharge and transfer of SSLC residents.[13]

Assistant Commissioner of SSLCs

SB 643 directed the DADS Commissioner to hire an Assistant Commissioner of SSLCs and in November 2009, Chris Adams was hired to serve in this capacity.[14]

Forensic SSLC for High Risk Alleged Offender Residents

SB 643 directed DADS to designate an existing SSLC as a forensic center for high risk alleged offender residents[15] and place such residents at, or transfer them from other SSLCs to, the forensic center. DADS designated Mexia SSLC the forensic center and expects Mexia SSLC to be fully operational by August 2011.[16] DADS is using an assessment tool to identify high risk alleged offenders at other SSLCs and transfer them to Mexia SSLC, beginning with Corpus Christi SSLC. As of September 2010, DADS identified five Corpus Christi SSLC residents for transfer to Mexia. Once this process is complete, DADS will develop a plan to assess and transfer individuals from other SSLCs who are determined to be appropriate for placement at Mexia.[17]

Annual Unannounced Inspections of Home and Community based Services

SB 643 directed DADS to conduct annual unannounced inspections of each Home and Community based Services (HCS) group home. In September 2009, DADS began conducting unannounced inspections of all HCS group homes and foster homes. DADS hired 20 additional surveyors located throughout the state to assist with this effort. As of July 2010, surveyors conducted over 8,500 annual inspections, including inspections of 6,745 foster/companion care homes and 1,841 three- or four-person group homes.[18] As a result of DADS' unannounced inspections, surveyors required corrective actions in 1,240 cases, identified significant risk in 82 cases and identified invalid locations in 98 cases.[19]

Shortly after DADS' surveyors began conducting these inspections, a number of foster/ companion care providers expressed concerns about when and how DADS' surveyors conducted these inspections. In response to their concerns, DADS instituted a number of procedural changes. In addition to these changes, DADS surveyors give providers a feedback card at the time of the inspection in order to collect input about the provider's experience. In fiscal year (FY) 2010, DADS received 2,168 feedback cards with responses. Of these, 2,106 responses were positive, 49 contained some negative feedback, and 13 were blank. DADS staff follow up on all responses containing negative feedback.

Investigation of Abuse, Neglect and Exploitation

Prior to the passage of SB 643, employees of licensed Intermediate Care Facilities for persons with Mental Retardation (ICFs/MR) who suspected abuse, neglect or exploitation of a resident were required to report such incidents to DADS' state office and conduct an internal investigation. This practice resulted in a potential conflict of interest due to the licensed ICF/MR provider investigating itself and its employees. In an effort to eliminate this potential conflict of interest, SB 643 required employees of licensed ICFs/MR to report suspected abuse, neglect or exploitation to the Department of Family and Protective Services (DFPS) and for DFPS to investigate these reports. In June 2010, DFPS began receiving and investigating reports of suspected abuse, neglect or exploitation at licensed ICFs/MR.[20]

Serious Event Definition and Notification Protocol

SB 643 required SSLC directors to ensure that residents' family members and legally authorized representatives are notified of serious events that may indicate problems in residents' treatment or care. In November 2009, DADS established a workgroup composed of SSLC residents, residents' family members, legally authorized representatives and DADS staff to determine what constitutes a "serious event." In September 2010, the serious event notification policy became effective.[21]

This policy defines a "serious event" as an event affecting two or more SSLC residents and indicating problems in the care or treatment of residents.[22] A serious event may include environmental disasters (e.g., flood, fire, tornado, hurricane); SSLC evacuation; negative media attention (e.g., newspaper, radio, internet or television reports alleging criminal activity); incidents involving sexual assault of a resident; and widespread confirmed diagnoses of certain conditions reportable to the Texas Department of State Health Services.[23] When a serious event occurs, the SSLC director must notify all residents, their families and legally authorized representatives and provide updates to these individuals as needed.[24]

*Appropriations*

The 81st Legislature appropriated $19 million in General Revenue funds during FY 2010–2011 ($39.8 million in All Funds) for SB 643 reforms. Table 1 includes funds appropriated for some of these reforms.

**Table 1. FY 2010–2011 Appropriations for SB 643 Major Provisions**

| SB 643 Reforms | General Revenue Funds | All Funds |
|---|---|---|
| Video surveillance | $10.7 million | $26 million |
| FBI fingerprint checks | $0.5 million | $1.2 million |
| Random drug testing | $0.1 million | $0.2 million |
| Office of Independent Ombudsman | $0.3 million | $0.6 million |
| Annual unannounced inspections | $0.5 million | $1 million |
| Forensic SSLC | $0.5 million | $0.5 million |

*DADS' FY 2012–2013 Legislative Appropriations Request*

For the next biennium, DADS' FY 2012–2013 Legislative Appropriations Request includes two Exceptional Items relating to the department's 13 SSLCs. The first is intended to provide intensive short term behavioral support services in ICFs/MR, including training for families to assist them in providing effective support for individuals returning home.[25] This Exceptional Item would require $18.8 million in General Revenue funds over the biennium ($47.6 million All Funds) to provide services to 144 individuals. The second Exceptional Item is needed to replace furniture, equipment and vehicles and maintain physical infrastructure (e.g., roof, heating, ventilation, air conditioning, plumbing, electrical). This Exceptional Item would require $20.2 million in General Revenue funds over the biennium ($102.9 million All Funds).[26]

*HHSC's FY 2012–2013 Legislative Appropriations Request*

For the next biennium, HHSC's FY 2012–2013 Legislative Appropriations Request includes two Exceptional Items relating to DADS' 13 SSLCs. The first is needed for technological improvements at the centers[27] and the second is needed to address high turnover among SSLC medical personnel by providing salary increases to nurses, mental retardation assistants and nursing assistants.[28] The Exceptional Item providing salary increases to certain SSLC medical personnel would require $24.9 million in General Revenue funds over the biennium ($56.5 million All Funds).[29]

*Advocates' Perspectives*

In light of the DOJ's findings, a number of advocates for individuals with intellectual and developmental disabilities support a moratorium on SSLC admissions, consolidation and closure of these facilities and the transfer of SSLC residents into community settings. These advocates believe community placements are safer and more integrated than SSLCs and provide residents with a greater sense of autonomy. However, other advocates strongly oppose these measures, believing a SSLC is the most appropriate placement option for certain individuals and that community placements may be unable to serve SSLC residents who are medically fragile or who have profound behavioral health needs.

**Implementation of Rider 48**

Rider 48 appropriated $207.9 million in General Revenue funds ($507.1 million in All Funds) to DADS for the 2010–11 biennium in an effort to reduce the disproportionately long wait time for services, expand Medicaid home and community-based services (HCBS) waiver program s' slots, and provide DADS direction related to reshaping the system of care for individuals with intellectual and developmental disabilities. Specifically, Rider 48 directed DADS to:

- Increase the number of waiver slots in the HCS, Community Living Assistance and Support Services (CLASS) and Deaf-Blind Multiple Disability (DBMD) waiver programs during FY 2010–2011;
- Reduce the number of SSLC residents through census management and identify SSLC residents through the community living options information process who could move into community programs; and
- Transfer the case management function from HCS providers to local Mental Retardation Authorities (MRAs).

Table 2 includes funds appropriated during FY 2010–2011 for some of these reforms.

**Table 2. FY 2010–2011 Rider 48 Appropriations**

| Rider 48 Reforms | General Revenue Funds | All Funds |
|---|---|---|
| Community expansion (7,016 new waiver slots) | $118.8 million | $289.1 million |
| HCS provider rate increase | $22.9 million | $55.7 million |
| Promoting Independence[30] (620 new HCS waiver slots) | $16.1 million | $35.6 million |
| Partial restoration of FY 2003 General Revenue reductions | $15 million | $15 million |
| MRA staffing and training | $9.5 million | $9.5 million |
| Prevention of institutionalization (196 new HCS waiver slots) | $4.6 million | $11.1 million |
| DADS Survey and Certification staffing | $2.1 million | $4.2 million |

Additional HCS, CLASS and DBMD Waiver Slots

Rider 48 allocated 5,936 HCS waiver slots to serve individuals moving out of medium and large ICFs/MR, children aging out of foster care at DFPS and individuals at imminent risk of institutionalization. As of August 2010, 462 individuals at imminent risk of institutionalization have been authorized to enroll in one of these new HCS waiver slots.[31] In addition to the new HCS waiver slots, Rider 48 allocated 1,890 CLASS waiver slots and 6 DBMD waiver slots.

A. Children Aging Out of Foster Care

As of June 2010, 101 children in DFPS' conservatorship were diagnosed with an intellectual or developmental disability and were receiving services in a residential treatment center. In addition to a disability, some of these children may also have behavioral health needs resulting from a prior history of abuse or neglect. Child Protective Services (CPS) policy requires caseworkers to ensure that these children are placed on all appropriate Medicaid waiver programs' interest lists as soon as the disability is identified.[32]

HCS priority slots are available for children aging out of foster care at DFPS who satisfy eligibility criteria for the HCS waiver program. Each biennium, DFPS receives 120 HCS priority slots for this population.[33] Younger children in foster care are not eligible for these priority slots until they age out of care. Instead, they may access HCS waiver services in the same manner as the general population, by registering their name on an interest list (operated on a first come, first served basis) and waiting for their name to be released from the list.[34]

DADS and DFPS are developing a plan to utilize HCS waiver slots for younger children in foster care in order to ease their transition from a residential treatment center to the community, when these children can be appropriately served in a less restrictive environment. In order to implement this plan, HCS slots will be needed both for younger children in foster care and for children aging out of foster care. DADS and DFPS will continue looking into this issue and will develop a plan for the 82nd Legislature's consideration.

Census Management

Rider 48 directed DADS to reduce the number of SSLC residents through census management, not closure. As of August 2010, 4,207 individuals reside at a SSLC, down from 4,769 in September 2008 and 4,532 in September 2009. Table 3 includes the number of individuals served in SSLCs from FY 2004–2009, reflecting a consistent downward trend. Local MRAs are also continuing to educate SSLC residents and their families or legally authorized representatives about available community placement alternatives to ensure they are aware of their placement options. In FY 2010, 133 individuals were admitted to a SSLC and 315 SSLC residents moved into community placements.[35] Among the new SSLC admissions, 114 individuals had behavioral health challenges and 81 had severe or profound needs for behavior management program services.[36]

**Table 3. Average Enrollment at Texas' SSLCs, FY 2004–2009[37]**

| Fiscal Year | Average Enrollment | Percentage Change |
|---|---|---|
| 2004 | 4,985 | N/A |
| 2005 | 4,977 | -0.16% |
| 2006 | 4,933 | -0.88% |
| 2007 | 4,909 | -0.49% |
| 2008 | 4,833 | -1.55% |
| 2009 | 4,629 | -4.22% |
| 2010 | 4,207 | -9.12% |

Transfer of Case Management to Local MRAs

Rider 48 directed DADS to transfer case management functions from HCS waiver program providers to local MRAs. In September 2009, proposed rule drafts were made available to all interested parties and DADS conducted public meetings to discuss implementation issues and communicate changes with families and providers.[38] In February 2010, DADS published proposed rule drafts in the Texas Register and received public comments regarding these drafts. In May 2010, DADS held a series of training sessions for HCS waiver program providers and MRAs and in June, case management transferred to the local MRAs. DADS' public website includes detailed information about this transition, including presentations, a frequently asked questions section, links to information letters, alerts and other notices relating to the transition and information regarding changes to the HCS waiver program's rules and handbook.[39]

Managed Care Study

Rider 48 also required the Health and Human Services Commission (HHSC) and DADS to jointly design a plan to implement a managed care pilot to serve individuals with intellectual and developmental disabilities. Rider 48 authorized HHSC to contract for this study and directed the study to include input from individuals receiving services, their families, service providers, MRAs, advocacy organizations and other interested parties and to include managed care models

used by other states to serve this population. In February 2010, HHSC awarded a contract to Health Management Associates (HMA) to complete the study and submit its report to HHSC. HHSC and DADS must submit a final report by December 1, 2010.[40]

**Implementation of Department of Justice Settlement Agreement**

Last session, the Legislature approved the system wide settlement agreement reached in May 2009 between Texas and the DOJ as a result of the DOJ's investigation of Texas' SSLCs.[41] In brief, the settlement agreement requires independent monitors, enhanced efforts to detect and deter abuse, and improvements to the level of care for Texans with intellectual and developmental disabilities. The settlement agreement is effective for five years. However, if any one SSLC substantially complies with all substantive terms of the settlement agreement for one year, the agreement may be terminated as to that SSLC. Alternatively, if a SSLC has not achieved substantial compliance with the settlement agreement terms, the agreement will extend beyond the five year period until the facility has achieved one year of substantial compliance. The settlement agreement is available online at http://www.justice.gov/crt/split/documents/TexasStateSchools_settle_06-26-09.pdf.

DOJ Monitors

The settlement agreement required Texas and the DOJ to jointly select monitors to conduct onsite baseline reviews[42] of each SSLC, then conduct onsite compliance reviews every six months thereafter in order to evaluate the centers' compliance with the settlement agreement terms. Each monitor has a monitoring team granted full access to all SSLCs to which it is assigned. Following each onsite visit, the monitoring teams issue reports indicating whether the SSLC is achieving substantial compliance with the settlement agreement terms.

In May 2010, the DOJ monitors completed their baseline reviews and in July 2010, the monitors began conducting compliance reviews of each SSLC. Table 4 includes the DOJ monitors' schedule for conducting baseline reviews and the first round of compliance reviews. The monitors' baseline and compliance reports are available on DADS' website at http://www.dads.state.tx.us/monitors/reports/index.html. These reports highlight a number of positive practices throughout Texas' 13 SSLCs as well as ongoing challenges.

**Table 4. DOJ Monitors Schedule for Baseline and Compliance Reviews**

| Facility | Baseline Review | First Compliance Review |
|---|---|---|
| Corpus Christi SSLC | 1/04/10 | 7/12/10 |
| El Paso SSLC | 1/11/10 | 7/19/10 |
| Brenham SSLC | 1/11/10 | 7/26/10 |
| San Antonio SSLC | 2/08/10 | 8/16/10 |
| Abilene SSLC | 2/22/10 | 8/2/10 |
| Rio Grande State Center | 3/01/10 | 8/23/10 |
| Lubbock SSLC | 3/15/10 | 9/13/10 |
| Mexia SSLC | 3/22/10 | 9/13/10 |
| Denton SSLC | 3/29/10 | 9/27/10 |
| Austin SSLC | 4/05/10 | 10/4/10 |
| Lufkin SSLC | 4/19/10 | 10/18/10 |
| Richmond SSLC | 4/26/10 | 10/25/10 |
| San Angelo SSLC | 5/10/10 | 11/15/10 |

A. Positive Practices

Generally, the DOJ monitors' baseline reviews found SSLC staff were open and honest regarding service delivery and compliance efforts; staff are committed to improving services and are aware of policies and procedures regarding the prevention, identification, reporting and investigation of abuse, neglect and exploitation. In addition, these reviews identified quality improvement efforts at each SSLC and policies and procedures that were either in place or in development to address the centers' compliance with the settlement agreement terms.[43]

B. Challenges

The DOJ monitors' baseline reviews also identified a number of challenges, including the lack of integrated services and the need to improve collaboration between clinical staff, direct care staff, residents and their families in order to plan, organize, implement and evaluate services. In addition, these reviews discussed centers' failure to provide sufficient assistive communication systems to all residents who would benefit from them and the need for proper communication devices. The monitors' reviews also discussed the need for additional staff at all centers, including direct care staff and staff in the areas of behavioral services, functional communication and psychiatry.[44]

The DOJ monitors' baseline reports also identified a number of challenges unique to certain SSLCs.[45] For example, the Austin and Lubbock SSLCs and the Rio Grande State Center each face significant staffing challenges. For example, the monitors' baseline review of Austin SSLC found a critical shortage of staff and a near 70% turnover rate (compared to an average turnover rate of 46% among direct care staff across all SSLCs). In an effort to increase staff retention at Austin SSLC, DADS increased the starting salary for direct care staff by 10%, a measure which should yield long term cost savings (due to reduced fees paid to contract staff). Although staffing across the 13 SSLCs has improved overall, DADS continues to face challenges maintaining appropriate staffing levels for registered nurses, physicians, psychiatrists and occupational, physical and speech therapists.

In addition to the staffing challenges at these centers, the DOJ monitors also cited Mexia SSLC for challenges in planning and follow through of community placements.[46] Specifically, the monitors' baseline review of Mexia SSLC discussed the rapidity of discharges without properly preparing community providers to care for individuals who, in some cases, have serious challenging (and often criminal) behaviors.

*Appropriations*

The 81st Legislature appropriated $48.2 million in General Revenue funds during FY 2010–2011 ($117.4 million in All Funds) for additional staffing, monitoring and training. Table 5 includes funds appropriated for these reforms.

**Table 5. FY 2010–2011 DOJ Settlement Agreement Appropriations**

| DOJ Settlement Agreement Reforms | General Revenue Funds | All Funds |
|---|---|---|
| DADS - Additional Staffing (1,160 SSLC staff)[47] | $38.5 million | $98.1 million |
| DFPS - Additional Staffing | $3.1 million | $5.5 million |
| Monitoring | $5.2 million | $10.4 million |
| Training | $1.1 million | $2.8 million |
| Onetime costs | $0.2 million | $0.6 million |

# Conclusion

Many of the 81st Legislature's sweeping reforms will be gradual and incremental. Although there are encouraging signs of progress, we still have a long way to go to make the service delivery system for individuals with intellectual and developmental disabilities the best it can be.

[1] Letter from U.S. Department of Justice Civil Rights Division to Governor Rick Perry, dated December 1, 2008, p. 5.
[2] "Report Update for State Supported Living Centers," p. 1, July 2010. Prepared by Texas Department of Aging and Disability Services (hereinafter referred to as "DADS Report Update for SSLCs").
[3] Reference Guide 2010, Texas Department of Aging and Disability Services, p. 79. *See also* "About the state supported living centers." Available online at http://www.dads.state.tx.us/services/stateschools/index.html (last accessed November 2, 2010).
[4] SSLC map available on DADS' website at http://www.dads.state.tx.us/services/stateschools/index.html (Last accessed November 2, 2010).
[5] Information provided by DADS via email dated November 3, 2010.
[6] *Id.*
[7] *Id.*
[8] DADS Senate HHS Presentation, slide 2.
[9] Information provided by DADS via email dated November 3, 2010.
[10] DADS Senate HHS Presentation, slide 5.
[11] Monthly Update: August–September 2010, Office of the Independent Ombudsman for State Supported Living Centers, p. 4–5 (hereinafter referred to as "Ombudsman Monthly Update Report").
[12] The Office of Independent Ombudsman is required to refer any contacts regarding abuse, neglect or exploitation to DFPS.
[13] Ombudsman Monthly Update Report, p. 4-5.
[14] DADS Senate HHS Presentation, slide 2.
[15] High risk alleged offender residents include alleged offender residents determined to be at risk of inflicting substantial physical harm to another.
[16] DADS Senate HHS Presentation, slide 4.
[17] *Id.*
[18] *Id.* at slide 6.
[19] Information provided by DADS via email dated November 3, 2010.
[20] DADS Senate HHS Presentation, slide 5.
[21] Information provided by DADS via email dated November 3, 2010.
[22] *Id.*
[23] *Id.*
[24] *Id.*

[25] DADS Presentation to the Legislative Budget Board and the Governor's Office of Budget, Planning and Policy, September 16, 2010, slide 13 (hereinafter referred to as "DADS Joint Budget Hearing Presentation"). Available online at http://www.dads.state.tx.us/news_info/presentations/LBBGOBPP-9-16-10pdf.pdf (Last accessed November 2, 2010).
[26] *Id.* The 81st Legislature did not allocate funding for replacement of furniture and equipment.
[27] Health and Human Services Commission Presentation to the Legislative Budget Board and the Governor's Office of Budget, Planning and Policy, September 15, 2010, slide 31. Available online at http://www.hhsc.state.tx.us/news/present81.asp (Last accessed November 13, 2010).
[28] *Id.* at slide 32.
[29] Information provided by HHSC via email dated November 16, 2010.
[30] In January 2000, Texas established the Promoting Independence Initiative following the U.S. Supreme Court's ruling in *Olmstead v. Zimring* requiring states to provide long term care services in the most integrated setting appropriate to the needs and wishes of individuals with disabilities. Since the Initiative began, 1,612 individuals have relocated to the community from state supported living centers and 1,188 have relocated from private ICFs/MR.
[31] DADS Senate HHS Presentation, slide 16.
[32] DFPS Presentation to the Senate Finance Committee, August 18, 2010, slide 5. Available online at http://www.dfps.state.tx.us/About/Legislative_Presentations/CPS/default.asp (Last accessed November 3, 2010).
[33] *Id.* at slide 8.
[34] *Id.*
[35] DADS Senate HHS Presentation, slides 21 and 23.
[36] *Id.*
[37] Table prepared by DADS. *See* DADS Report Update for SSLCs, p. 3.
[38] Information provided by DADS via email dated May 27, 2010.
[39] See "Home and Community-based Services (HCS) Case Management Transition" on DADS website at http://www.dads.state.tx.us/hcscmtransition/index.cfm (Last accessed November 3, 2010).
[40] For additional information about the managed care pilot, go online to http://www.hhsc.state.tx.us/ManagedCarePilot.shtml.
[41] SCR 77 (81R; Nelson/Rose). State law requires the Legislature to approve any settlement of a claim or action against the state if it will likely require the state to expend state funds over subsequent fiscal biennia.
[42] Baseline reviews are intended to give the monitors and the state an accurate picture of the starting point for each facility and identify areas where service delivery improvements are required. For additional information about the monitors' baseline reports or to view these reports, go online to http://www.dads.state.tx.us/monitors/reports/index.html.
[43] DADS Senate HHS Presentation, slide 10.
[44] *Id.* at slide 11.
[45] *Id.* at slide 12.
[46] *Id.*
[47] As of July 2010, DADS' filled positions were 95.19%, up from 87.93% in December 2009 and direct care staff positions were 98.46% filled, up from 89.79% in December 2009.

CAPITOL OFFICE
P.O. Box 12068, Room E1.708
Austin, Texas 78711
(512) 463-0103
FAX: (512) 463-1526
Dial 711 for Relay Calls

COMMITTEES:
Intergovernmental Relations, Vice Chair
Subcommittee on Flooding & Evacuations
Health & Human Services
Nominations
Transportation & Homeland Security

**ROBERT L. NICHOLS**
STATE SENATOR

November 29, 2010

The Honorable Jane Nelson
State Senator
P.O. Box 12068
Austin, Texas 78711-2068

Dear Senator Nelson:

Thank you for your leadership of the Senate Committee on Health and Human Services. I am pleased to attach my name to the committee's interim report to the 82nd Legislature. I also wish to express several comments in relation to the recommendations.

*Charge 5: Study the state's current and long-range need for physicians, nurses, dentists and other allied health and long-term care professionals.*

The interim report recommendations suggest several concepts to attract primary care physicians to medically underserved areas. While I strongly agree new tools must be developed, I respectfully submit that the committee should also evaluate whether the Physician Loan Repayment Program (House Bill 2154, 81 Regular Session) can be enhanced to ensure Texans in particularly rural, medically underserved areas have greater access to primary care. As we heard during testimony from the Department of State Health Services, 26 counties have no primary care physician, and 18 counties have only one primary care physician.

*Charge 7: Examine how the state could enact policies to improve the overall health of Texans, focusing on programs that compliment individually-based prevention and community-based prevention to reduce obesity rates by increasing physical activity, improving nutrition, and improving self-management of chronic diseases such as diabetes.*

The recommendation to utilize unleased state property to cultivate community gardens may complicate the mission of the General Land Office to maximize returns to the Permanent School Fund. I respectfully submit the committee should not act to involve the state in activities where other organizations are already contributing to wellness programs using private and other non-profit resources.

JACKSONVILLE OFFICE
329 Neches Street
Jacksonville, Texas 75766
(903) 589-3003
FAX: (903) 589-0203

NACOGDOCHES OFFICE
202 E. Pillar St., Ste. 208
Nacogdoches, Texas 75961
(936) 564-4252
FAX: (936) 564-4276

LUFKIN OFFICE
4100 S. Medford Dr.
Lufkin, Texas 75901
(936) 699-4988
FAX: (936) 699-4991

CONROE OFFICE
2040 N. Loop 336 W., Ste. 107, Box 7
Conroe, Texas 77304
(936) 756-5168
FAX: (936) 756-5170

Senate District 3
E-mail: robert.nichols@senate.state.tx.us

I strongly agree Texas faces a serious health crisis, and the committee has a responsibility to promote healthier decisions. However, I must express my reservations about requiring daily physical activity for all public school children. I welcome the opportunity to work with you to find a solution that promotes healthy school children without sacrificing academic instruction.

*Charge 12: Review the Medicaid Home and Community Based Services waivers and develop recommendations to assure that people with significant disabilities, regardless of disability label or age, receive needed services to remain in or transition to the community.*

Recommendation 2 directs the Department of Aging and Disability Services to require program providers to convert existing 3 and/or 4 beds residential models to 6 bed models. It is my understanding some states allow up to 35 bed models. I respectfully submit that consumers should be afforded the greatest degree of choice when evaluating what community setting they desire to receive care in, and that while a 6 bed model is a step in the right direction, there may be additional opportunities for state savings and consumer satisfaction by going beyond a 6-bed model.

Again, thank you for your leadership, and thank you for your staff's diligent work during the interim to prepare recommendations for the 82nd Legislature. I look forward to working together. Please do not hesitate to contact me whenever I may be of assistance.

Sincerely,

Robert L. Nichols
State Senator

RLN/al/pc

CAPITOL OFFICE
P.O. BOX 12068
ROOM E1.810
AUSTIN, TEXAS 78711
(512) 463-0119
FAX: (512) 463-1017
DIAL 711 FOR RELAY CALLS

EAGLE PASS DISTRICT OFFICE
MAVERICK COUNTY COURTHOUSE
501 EAST MAIN STREET, SUITE 114
EAGLE PASS, TEXAS 78852
(830) 758-0294
FAX: (830) 758-0402

The Senate of The State of Texas

Senator Carlos Uresti
District 19

SAN ANTONIO DISTRICT OFFICE
FALCON INTERNATIONAL BANK
2530 SW MILITARY DR., SUITE 103
SAN ANTONIO, TEXAS 78224
(210) 932-2568
FAX: (210) 932-2572

PECOS DISTRICT OFFICE
312 SOUTH CEDAR
PECOS, TEXAS 79772
(432) 447-0270
FAX: (432) 447-0275

DIAL TOLL FREE: 1-800-459-0119

Nov. 30, 2010

Honorable Jane Nelson
Chairwoman
Senate Committee on Health & Human Services
VIA HAND DELIVERY

RE: Health & Human Services Interim Report

Dear Chairwoman Nelson:

I deeply appreciate the hard work behind the drafting of the Health and Human Services Interim Report for the 82nd Legislature. Your leadership and the commitment of your staff are evident throughout this document. I respectfully request, however, that you append this letter to the report.

As you well know, charge #2 directed the committee to do essentially three things: study the benefits, efficiencies, costs, and effectiveness related to prevention and early intervention programs; assess the effectiveness of prevention efforts in other states via a merged prevention department; and provide recommendations to improve efficiencies and effectiveness of these programs.

Unfortunately, the report fails to adequately address the merits or benefits of prevention and early intervention programs, which I believe have demonstrated a cost-effective benefit to protecting at-risk children in Texas.

As we ask state agencies to identify cost savings to address the budget deficit, it is both prudent and necessary to recognize that such programs address a critical need in stemming the growing crisis of child abuse and neglect in our state. By any measure, we have to acknowledge that prevention efforts are working and must continue to be a major weapon in our arsenal against abuse.

In the past, most Health and Human Services Commission agencies have received funding increases each biennium to keep pace with the growth in caseloads, inflation and other factors. Sadly, the Prevention and Early Intervention Division within HHSC is an example of where this trend has not held true. While the child population is expected to increase nearly 12.4% since 2002 — to more than 7.1 million — funding for the PEI division increased a mere 1.8 percent.

CARLOS URESTI
TEXAS STATE SENATOR
DISTRICT 19

That is not nearly enough to keep pace with the growing needs of this population, yet proposals on the table would not only fail to maintain the resources we have provided in this battle, they would gut our prevention efforts and erase any gains that we have made or hope to make.

Funding of child abuse prevention programs is crucial to breaking the pattern of abuse that is commonly found in families who are challenged by poor job skills, illiteracy, poverty, immaturity and past histories of abuse. According to a landmark study by Prevent Child Abuse America, child abuse and neglect costs the nation $104 billion nationally. That equates to an approximate annual cost of $2.47 billion in Texas, including $1.1 billion alone for Child Protective Services.

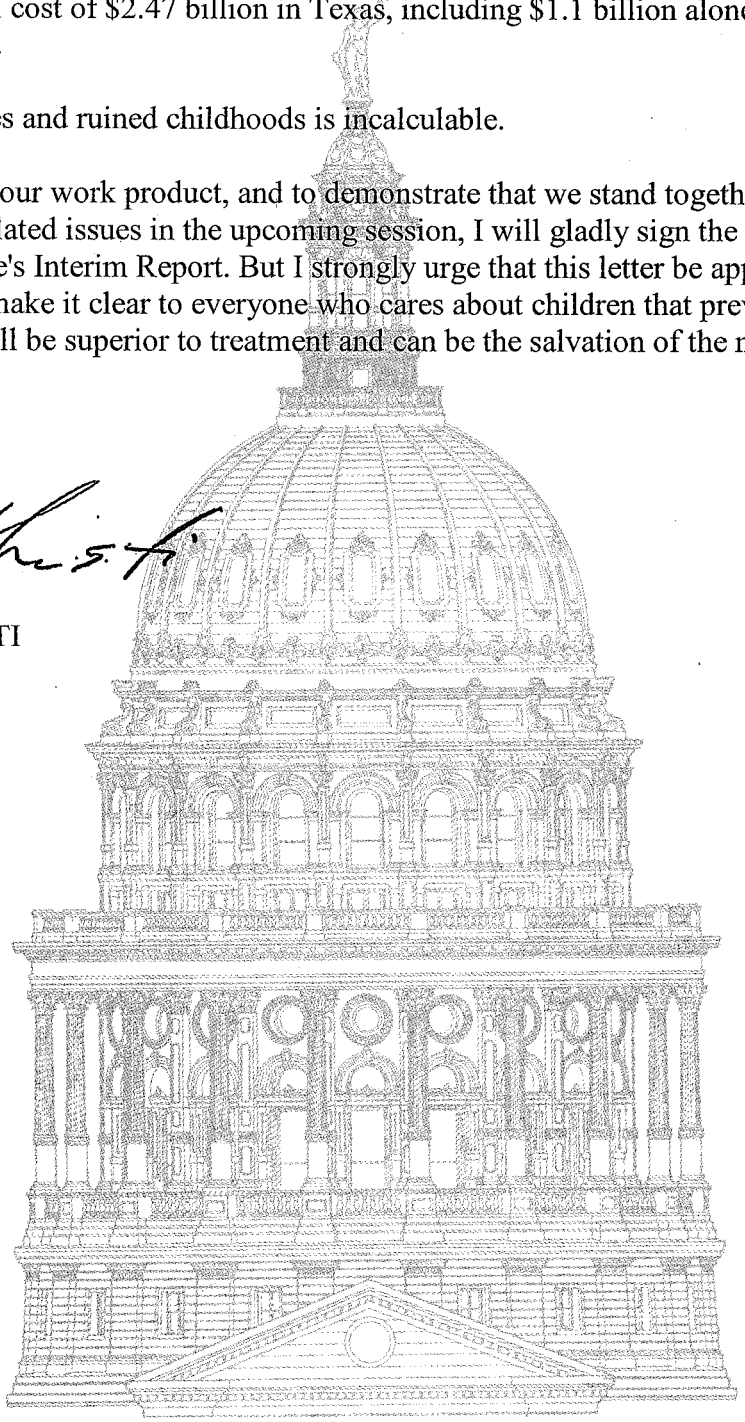
The cost in lost lives and ruined childhoods is incalculable.

With great pride in our work product, and to demonstrate that we stand together on these vitally important health-related issues in the upcoming session, I will gladly sign the Health and Human Services Committee's Interim Report. But I strongly urge that this letter be appended. Our committee should make it clear to everyone who cares about children that prevention has always been and always will be superior to treatment and can be the salvation of the most vulnerable among us.

Sincerely,

CARLOS I. URESTI

CIU/jh/ml



# The Senate of The State of Texas


SENATE COMMITTEES:

CHAIRMAN
Intergovernmental Relations

MEMBER
Education
Finance
Health and Human Services
Higher Education

**Senator Royce West**
District 23

**President Pro Tempore**
2006

DISTRICT OFFICE:
5787 South Hampton Road
Suite 385
Dallas, Texas 75232
214/467-0123
Fax: 214/467-0050

DISTRICT OFFICE:
2612 Main Street, Suite 100
Dallas, Texas 75226
214/741-0123
Fax: 214/749-7830

CAPITOL OFFICE:
P.O. Box 12068
Austin, Texas 78711
512/463-0123
Fax: 512/463-0299
Dial 711 for Relay Calls


November 30, 2010

Honorable Jane Nelson
Chair
Senate Committee on Health and Human Services
State Capitol, Room 1E.5
Austin, TX 78701

Dear Madam Chair Nelson:

Please accept my thanks to you and your committee staff for your hard work this interim. We explored a number of challenging topics over the last several months, and the interim report reflects thorough analysis and makes a number of good recommendations.

By this letter, however, I specifically reserve endorsement of Charge 9, Recommendation 3, which states "(t)he Health and Human Services Commission should develop and implement Medicaid copayments for unnecessary emergency room visits." While I agree that such visits are a cost to the Medicaid system, I am concerned that the suggested co-payments will not serve as a practical deterrent to emergency room visits and may ultimately penalize people for behavior that is reasonable from their perspective. For example, while providers may be able to employ their expertise, experience and sophisticated billing codes to easily distinguish between emergency and non-emergency situations, a layperson might not. As the report notes, non-emergency conditions can be "**lacerations**, minor infections, **fractures**, and strains." A person who is bleeding profusely or has a broken bone might view their situation a little differently than a trained professional, and might be unwilling to make an appointment to see a primary care physician or locate an urgent care center.

Additionally, I know that we will all be working to increase the number of primary care physicians in Texas, but right now there is a shortage. Perhaps it might be more prudent to let those efforts bear fruit before we impose costs on folks for seeking care outside of that environment.

Again, thank you and your staff for your efforts in compiling this valuable report. I am committed to reducing Medicaid costs and remain open to this particular idea in the future. But at this time, I believe more study is warranted.

Sincerely,

Honorable Royce West
State Senator, District 23

Chair, Higher Education Committee
Legislative Budget Board

Judith Zaffirini
State Senator, District 21
President Pro Tempore, 1997

Committees
Administration
Economic Development
Finance
Health and Human Services

November 30, 2010

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 Committee's interim report. Because the report includes many fine recommendations that could improve the quality of health and human services for Texans, I am delighted to sign it; however, I submit this letter to be included in our interim report as a record of some of my concerns. In the interest of brevity I am commenting herein only about three.

First, the recommendation (Charge 12) to expand the three- and four-bed HCS group home model to a six-bed HCS group home model goes against the very nature of the Home and Community Services (HCS) program, which is to provide community-based services and supports in persons' homes or home-like settings. Requiring HCS providers to convert their three-four bed operations to six-bed operations is contrary to consumer choice and forces people to live in larger residential settings. Texas should be promoting community and home-like settings, instead of growing small institutions.

It is important to note that as the HCS program is expanded, the majority of enrollees are opting to receive services in their homes or the homes of their loved ones. Overall, the use of three- and four-bed HCS group homes is continuing to decline.

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 Toepperwein Road #214 • San Antonio, Texas 78233 • 210/657-0095 • Fax 210/657-0262

What's more, requiring an industry that likely will receive substantial rate reductions in the next biennium to convert without providing transition costs will put the whole system in peril. Moving forward with a recommendation without first examining whether cost savings could be achieved appears somewhat premature. The data referenced in the SHHSC report is outdated and was modeled without full consideration of all cost factors. While the recommendation does not address the actual rate and whether transition costs would be covered, the report on which the recommendation was based offered various cost scenarios related to such a transition. This report references only one option.

This recommendation should direct a study of the conversion to determine whether cost savings could be achieved. A comprehensive process should be developed for exploring the interest of families/consumers whose names are on the current HCS Interest List in receiving services through the six-beds ICF program while waiting for HCS services to become available or on a long-term basis.

Second, regarding the recommendation relating to the Medicaid home and community-based services waivers (Charge 12), the subsection relating to the Money Follows the Person (MFP) Program should include the total cost savings to the state that has resulted from the MFP Demonstration Project and, in particular, the savings that have resulted from providing services to persons with intellectual and developmental disabilities (IDD) in their communities instead of in large ICFs/MR. It is critical that the report state that any cost savings resulting from this project be reinvested in community-based services and supports for persons with IDD.

Relating to prevention and early intervention services in Texas, additional data and information would have clarified the committee's recommendations and intent. It is concerning that the focus is on the cost of services in institutional settings [as shown in Figure 1, Page 2 of charge 2], rather than on community-based programs. The report reflects the high cost of rehabilitation services upstream when a youth or adult is incarcerated, but this section also should have highlighted the cost of community-based prevention and diversion services available at the local level, such as prevention services offered by juvenile probation departments.

Relating to supporting the needs of aging Texans (Charge 6a), the state should avoid duplication and delineate clearly the roles of Aging and Disability Resource Centers (ADRCs) and MH/MR centers. Both offer similar, overlapping functions to similar, overlapping populations. The only recommendation for this section refers to a study about how persons arrive at the front door of the nursing facility. While the inclusion of this recommendation is positive, additional recommendations about increasing access to, or the scope of, community-based services would have been more thorough and beneficial.

Finally, while the report for Charge 5 relating to the current and long-term need for health care professionals in Texas is well written, the information regarding the Transition Medicine population could be expanded and included throughout the report. This introductory section does a great job of setting the stage for underscoring the position that "primary preventative care is the key to heading off the state's chronic disease crisis." The report also notes that many Texans, not only the elderly, suffer from chronic conditions, many of which stem from obesity. A major gap, however, is the fact that the introductory paragraph fails to recognize a population that is just now surfacing, yet promises to expand in the near future: children and youth with disabilities and with chronic conditions who are transitioning into adulthood.

Thank you for your dedication to these important issues. I look forward to our continued productive relationship during the forthcoming legislative session. Count on my continued leadership to ensure that every Texan has access to quality health and human services. May God bless you.

Very truly yours,

Judith Zaffirini

Judith Zaffirini

JZ/sh