TEXAS SENATE
COMMITTEE ON HEALTH AND HUMAN SERVICES

INTERIM REPORT
TO THE
86TH LEGISLATURE

November 2018

THE SENATE OF TEXAS
COMMITTEE ON HEALTH AND HUMAN SERVICES

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November 29, 2018

The Honorable Dan Patrick
Lieutenant Governor of Texas
P.O. Box 12068
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Dear Governor Patrick:

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

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

Respectfully submitted,

Senator Charles Schwertner
Chair

Senator Lois Kolkhorst

Senator Dawn Buckingham

Senator Konni Burton

Senator Charles Perry

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Interim Charge 1A: State Health Response

Interim Charge Language: *Review the state's response to Hurricane Harvey with a focus on public health efforts at the local and state level. The review should include an analysis of the state and local response related to vector control, immunization needs, utilization of health-related volunteers, adequacy of an emergency medical network, evacuation of vulnerable populations from state operated or regulated facilities, and coordination between all levels of government. Recommend any legislative changes necessary to improve public health response and coordination during and after a disaster.*

Hearing Information

The Senate Committee on Health and Human Services hearing was held on November 8, 2017. Individuals representing the Department of State Health Services (DSHS), the Health and Human Services Commission (HHSC), and Local Public Health Departments provided invited testimony.[1]

Introduction and Background

On August 25, 2017, Hurricane Harvey made landfall along the Texas coast as a Category 4 storm with winds of 130 miles per hour. Over several days, the storm dumped 40-60 inches of rain on Houston and coastal and southeast Texas, causing unprecedented flooding, destroying thousands of homes and businesses, and leaving behind damages totaling approximately $180 billion.

During a disaster, DSHS supports the medical emergency response portion of the state's disaster preparedness plan under the Texas Division of Emergency Management (TDEM), while local health departments (LHDs) provide the front line public health response at the local level. DSHS's role includes activities such as medical evacuations, sheltering, public health and medical support in conjunction with local partners, and operation of the State Medical Operation Center (SMOC), which, among other things, facilitates the acquisition and use of state public health and medical resources.

While the State's public health response to Harvey was successful, improvements can be made. The following outlines those successes and highlights areas in need of improvement.

Public Health Preparedness Activities

Before each hurricane season, DSHS updates plans, procedures, and staff training to ensure response readiness. For example, in June of 2016, DSHS conducted an eight day evacuation exercise in conjunction with TDEM.[2] There was also a focus on raising public awareness about preparation for Harvey's landfall. Awareness information can be found at www.texasprepares.org, a website maintained and operated by DSHS.

The state's health professional shortage is exacerbated during disasters. To ensure there are adequate numbers of health professionals to respond in disaster situations, DSHS administers the Texas Disaster Volunteer Registry (TDVR) that allows volunteer health professionals and other volunteers to register as responders with participating local organizations. Like other disaster response activities, volunteer deployment and coordination happens at the local level. As of

November 2, 2017, there were 13,551 volunteers registered in the TDVR. During Harvey, 3,861 volunteers registered.[3]

Facility Emergency Evacuation Protocols and Preparedness

Beginning September 1, 2017, a new Regulatory Division at the Health and Human Services Commission (HHSC) was established per Senate Bill 200 (84R), which reorganized the Health & Human Services agencies in Texas. HHSC regulatory staff ensures providers develop and implement evacuation plans that coincide with HHSC minimum standards. HHSC reviews emergency preparedness plans on regular surveys and will cite a facility if a required element of an emergency preparedness plan is missing; however, HHSC surveyors do not make determinations or judgments about the facility's plan (i.e. whether or not the plan sound or feasible). HHSC alerted providers prior to the storm to review their disaster and evacuation plans. If a facility is not located in a mandatory evacuation area, it is the facility's choice whether to evacuate or shelter in place.[4]

Public Health Response Activities

DSHS activated the SMOC on August 24. As the lead state agency for public health response, DSHS:

- Deployed over 700 emergency medical task force personnel, over 90 ambulances, more than 10 ambulance buses, and multiple helicopters;
- Activated federal resources from the U.S. Department of Health and Human Services and the Federal Emergency Management Agency including nearly 20 disaster medical assistance teams, over 200 ambulances, and over 50 air ambulances;
- Evacuated nearly 3,200 patients from hospitals;
- Established shelters in San Antonio, Houston, and Austin to serve evacuees with medical needs;
- Executed contracts with HEB, CVS, Walgreens, Brookshire Brothers, Wal-Mart, and Sam's Club to help fill prescriptions; and
- Enacted rapid response teams to manage the assessment of food, drug, device, and biologics firms to ensure that damaged products that would be unsafe for use were removed from distribution.[5]

State and local public health priorities immediately after landfall included mosquito control, immunizations, and re-opening of health care facilities.

Mosquito Control – The standing water left in the wake of Harvey created additional mosquito breeding grounds. Controlling the mosquito population lowers the chance of a mosquito borne disease outbreak and lessens the overall nuisance created for individuals in the affected area. To do this, DSHS activated a number of contracts for aerial mosquito spraying which began on September 7, 2017. Of the 60 counties included in the Governor's State Disaster Declaration, 28 opted-in for state/federal assistance for aerial spraying.[6] Whether or not to opt-in to aerial spraying is a local decision; some local authorities had resources to address the issue without state assistance. In total, more than 6.5 million acres were sprayed.[7]

Immunizations – Stopping the spread of flu and providing tetanus shots to individuals who waded through standing water become a priority for state and local public health workers. DSHS worked closely with LHDs and providers to address the high demand for immunizations and fill local vaccine requests as quickly as possible. As of September 22, 2017, DSHS provided over 70,000 vaccinations to local authorities.[8]

Health Care Facilities - HHSC worked closely with the SMOC during facility evacuation and re-opening efforts. Facility damage at a glance[9]:

a. Of approximately 1,200 Nursing Facilities and 1,957 Assisted Living Facilities, 104 facilities evacuated 4,486 residents due to the storm. Three nursing facilities are permanently closed and nine are temporarily closed. Seven assisted living facilities are temporarily closed

b. Of the 805 ICFs in Texas, 61 ICFs evacuated 559 residents. Two closed permanently.

c. More than 60 hospitals and dialysis centers have been inspected since the storm. All dialysis facilities have re-opened, however, three hospitals remain closed.

d. A total of 1,147 child care operations reported to be affected by the hurricane at some point, with 94,579 potentially displaced children based on the operation's capacity at the height of the disaster. Four child care operations remain closed, for a total capacity loss of 185.[10]

State Supported Living Centers (SSLCs) fared well during the storm and had an effective response to Harvey. In total, 214 residents and 205 staff were evacuated from the Corpus Christi SSLC to the San Antonio SSLC successfully.[11] Additionally, SSLCs in Richmond, Brenham, and Lufkin sheltered their residents and other individuals from the community with IDD and medical needs. All SSLCs, with the exception of the Rio Grande Center, are equipped with an electronic medical health record system that allowed for the seamless transition of Corpus SSLC residents to San Antonio with no care distribution.

Issues and Recommendations

While the state's public health response to Harvey was successful, there are a number of areas in need of improvement.

Communication - Disaster response involves many governmental and non-governmental entities. The health related response to Harvey included FEMA, USDA, HHSC, DSHS, DFPS, LHDs, counties, hospitals, providers, health plans, and others. Due to the sheer number of entities involved, confusion and a lag in communication occurs. For example, LHDs weren't fully aware of where or when vaccines would be distributed.

- Recommendation:
  - **DSHS, in conjunction with TDEM leadership, should consider ways to allow a representative from major health related associations to be located within the SMOC.** All public health emergency response information flows through the SMOC. Allowing organizations like THA, TMA, TACCHO, and TAHP to be

physically located in the SMOC will create a quicker and smoother information transfer for all parties. These organizations represent thousands of providers, their ability to get information to their members will greatly improve the communication process. If it is not feasible to physically locate more individuals within the SMOC, the agency should consider establishing direct lines of communication with these organizations.

Volunteers – The sheer number of volunteers creates management issues. When an individual registers as a medical volunteer through the TDVR, they must select a local, county-level organization that is affiliated with the TDVR. Deployment and coordination happen locally, usually by the Medical Reserve Corps (MRC), however, not all counties have a MRC. Since county resources vary, most counties have a different list of registered organizations while some counties lack a single organization. The Texas Medical Association (TMA), who referred physicians that wanted to volunteer to MRC units, testified that "while urban areas have active MRC units, MRC is not well known in other parts of the state, resulting in slower deployment of volunteers in hard-hit small and rural towns."[12]

- Recommendations:
  - **DSHS, in conjunction with TDEM, should ensure local authorities are aware of and have access to an MRC.**
  - **DSHS should consider ways to create and manage state controlled medical volunteer mobile units within each public health region to assist counties that lack a strong medical volunteer force.**

Specialty Shelters – Not all shelters were equipped to properly care for certain medically needy populations, such as those that are technology-dependent. For example, a number of dialysis centers closed due to Harvey and shelters were not equipped to handle the influx of dialysis patients, thus the patients were transferred to hospital ERs that were already beyond their care capacity.

- Recommendation:
  - **Local emergency response networks, in conjunction with TDEM, should ensure shelters are capable of caring for certain specialty care populations.**

Physical and Mental Health - Umair Shah, the Executive Director of Harris County Public Health, testified to the increased mental health needs of individuals in the disaster area. A study released by the Kaiser Foundation in December 2017, found that "one in six affected residents say someone in their household has a health condition that is new or worse as a result of Harvey, and nearly two in ten feel that their own mental health is worse because of the storm. Among those with a new or worsened health condition, six in ten say they have skipped or postponed needed medical or dental care, cut back on prescriptions, or had problems getting mental health care since the storm."[13] Additionally, Governor Abbott and the Texas Education Agency created the Hurricane Harvey Task Force on School Mental Health to help connect Harvey-affected schools with mental health resources.

- Recommendations:
    - **The Legislature should protect previous investments made in the statewide mental health and public health system.**
    - **The Legislature should continue to support mental health programs like Mental Health First Aid and the Mental Health Professional Loan Repayment Program.** The Task Force on School Mental Health surveyed teachers across the state and found that teachers would like more information on how to assist students with mental health needs.[14] Mental Health First Aid is a program designed to give individuals the training and tools needed to support those in immediate need. This training is currently provided at local mental health authorities at no cost for school staff.

Electronic Medical Record – As stated above, the electronic medical record used by the SSLC system provided continuity of care for residents transferred from Corpus Christi to San Antonio.

- Recommendations:
    - **The Legislature and HHSC should consider equipping the Rio Grande SSLC with the SSLC system wide electronic medical record.**
    - **The Legislature and HHSC should examine the state of electronic health systems in other state operated health facilities to ensure continuity of care during evacuations caused by future disasters.**

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List*, November 8, 2017: http://www.legis.texas.gov/Committees/MeetingsByCmte.aspx?Leg=85&Chamber=S&CmteCode=C610
[2]Information provided by the Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, November 8, 2017.
[3] *Supra* note 2.
[4] Information provided by the Health and Human Services Commission via email on November 1, 2017.
[5] *Supra* note 2.
[6] Information provided by Department of State Health Services via email on November 2, 2017.
[7] *Supra* note 4.
[8] Information provided by Department of State Health Services via email on November 6,2017.
[9] Information provided by Health and Human Services Commission via email on October 23, 2018.
[10] Information provided by the Health and Human Services Commission via email on October 18, 2018.
[11] Information provided by the Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services*, November 8, 2017.
[12]Information provided by the Texas Medical Association, *Testimony before the Senate Committee on Health and Human Services*, November 8, 2017.
[13] Kaiser Family Foundation, *An Early Assessment of Hurricane Harvey's Impact on Vulnerable Texans in the Gulf Coast Region*, December 2017.
[14] Information provided by Texas Education Agency, *Testimony before the Senate Committee on Finance*, March 20, 2018.

Interim Charge 1B: Child Welfare System Response

Interim Charge Language: *Evaluate the impact of Hurricane Harvey on the capacity of out-of-home placements and care for youth involved with the juvenile justice and child welfare systems. Determine how the state can ensure support is available to provide appropriate care as close to home as possible as facilities and offices are rebuilt.*

Hearing Information

The Senate Committee on Health and Human Services hearing was held on November 8, 2017. Individuals representing the Department of Family and Protective Services (DFPS), the Texas Juvenile Justice Department (TJJD), Upbring, Harris County Juvenile Probation, and Harris County Protective Services for Children and Adults provided invited testimony.[1]

Introduction and Background

Texas children and youth involved in the Child Protection Services (CPS) system or the juvenile justice system endured trauma when removed from their household. Further trauma from the impact of a historic natural disaster such as Hurricane Harvey has the potential to exacerbate past traumas and inflect new trauma on this vulnerable population. It is important that stakeholders in Texas understand the impact of Hurricane Harvey on this population, and the affect this storm had and will continue to have on continuity of care and capacity in the CPS and juvenile justice systems. This report aims to apply lessons learned and best practices to protect children and families who were affected by Hurricane Harvey and prepare for future disasters.

Child Protective Services (CPS) is a state run system overseen by the DFPS. DFPS oversees all providers, including those who run and manage foster homes, Child Placing Agencies (CPAs), Residential Treatment Centers (RTCs), General Residential Operations, emergency shelters, and more. Whether these facilities and homes are privately-run or state-run, it is the role of DFPS to ensure all emergency preparedness protocols are met. Approximately 90 percent of CPAs and all RTCs are privately-run, meaning that DFPS has oversight over a privately-run system. There are around 30,000 children in CPS care daily which includes children in foster care and kinship care.[2]

Juvenile Justice

In contrast to the state run CPS system, the juvenile justice system in Texas is run by each county. 98 percent of the system is run by counties; the remaining two percent include state-run facilities. The Texas Juvenile Justice Division (TJJD) has 1,024 youth in its facilities daily, while Harris County has 550 in its facilities daily. This is due to a shift in the last couple of decades towards ensuring children and youth stay in the area they are from, and are not moved across the state. [3]

In addition, TJJD oversees the counties' emergency management plans, but each county's plan is unique. TJJD does have the authority to waive standards as appropriate for every county, which the agency did during Hurricane Harvey. TJJD has a preparation planning session which begins annually in May. This session includes a review of every county's emergency and disaster plans, and any necessary preventative maintenance.[4]

Hurricane Harvey Damage

Texas children in the CPS and juvenile justice systems were greatly impacted by Hurricane Harvey. In all, 1,500 children were evacuated from CPS facilities and homes in affected areas. Only two DFPS licensed facilities remained closed immediately following the storm, and all 19 children in those facilities were moved to other RTCs. As of December, all facilities were open. In addition, all foster and kinship children remained in foster and kinship families they were placed in immediately after the storm, even if a family was displaced to another county. Children faced school disruptions as their foster and kinship families were displaced. DFPS constantly worked with CPAs and private providers to ensure children were safe and remained in care.[5]

While county facilities sustained damage, all children and youth in TJJD facilities remained in place and were not affected by the storm. The TJJD Giddings facility is the only facility that sustained damage, which was minor and did not require youth to be evacuated, or affect day to day activities. [6]

Communications and Immediate Assistance After Storm

CPS

It was imperative that state agencies maintained contact with local providers and counties during the storm to first ensure child safety, and also ensure appropriate resources and staff were sent to sustain safety, services, and supports needed for children and youth in care and families receiving services.

DFPS was in contact with providers to ensure all children were safe before, during, and after the storm. Through the dissemination of e-mails, flyers, and Frequently Asked Questions documents on how individuals can help, the agency was able to ensure outside entities with support and resources were able to communicate with providers and facilities needing help and intervention.

For example, DFPS staff shared links and phone numbers to community resources that families in the affected areas could utilize, and the Prevention and Early Intervention department provided resources to parents, caregivers and service providers on how to explain the disaster to children who are coping with trauma. Finally, CPS and APS have emergency resource rooms throughout the state that provide necessities for the abused and neglected. The rapid inpouring of donations to these facilities from outside entities helped provide essential goods for families and individuals affected by the storm. [7]

TJJD

Because juvenile justice facilities are mostly operated by counties, it was up to counties after the storm to connect families with resources. The Harris County Juvenile Probation connected families to resources in their immediate communities, by posting information online and helping refer families to support families in need. [8]

Emergency Protocols in Place

DFPS
While support after the storm is critical, it is up to stakeholders, state agencies, and counties to ensure DFPS has implemented appropriate standards and protocols that will support children and families in the case of a natural disaster. In addition, appropriate enforcement by DFPS must occur to ensure CPAs and General Residential Operations (GROs) keep children and families safe. For example, HHSC minimum standards require all licensed facilities such as Residential Treatment Facilities (RTCs), group homes, and day care facilities to have protocols in place to ensure safety of children in disasters, including evacuation procedures. These standards are updated and reviewed regularly by DFPS staff as well as outside stakeholders.

TJJD
The Texas Administrative Code outlines the requirements for county-run TJJD facility emergency response protocols. TJJD is required to ensure all county and state facilities include the following in their emergency plans: identification of key personnel and their specific responsibilities during an emergency or disaster situation; procedures for alerting, notifying, activating, and deploying employees; outlining mission-essential functions; alternate sites for the evacuation of residents; and identification of staff members with authority and knowledge of functions; overview of agreements with other agencies or departments; and ability to transport individuals to pre-determined evacuation sites.

TJJD has the ability to waive emergency protocol standards for counties during disaster situations, which they did in Hurricane Harvey. County probation chiefs notified TJJD in writing of any standards they needed waived as a result of the hurricane. For the purpose of expediency during the emergency, instead of issuing formal waivers, the probation departments were told that their requests for waivers would be maintained and used by TJJD staff during future monitoring visits so that they would not be found non-compliant during the time period identified in the emails. [9]

Appropriate Staffing

DFPS
Over 100 DFPS staff were permanently displaced due to Hurricane Harvey, and thousands of staff were impacted due to evacuation and personal property damage. In response, DFPS staff contributed more than $27,000 to the *DFPS Cares* fund and the money was equally divided amongst 108 DFPS employees who were displaced from their homes. In addition, slower intakes during the storm and many of the impacted staff continuing to work their caseloads prevented DFPS from having to mobilize hundreds of staff. In total, DFPS sent 15 Family-Based Safety Services (FBSS) staff to the affected area temporarily to help with FBSS caseloads, and about 35 staff from the State office in Austin went to help with other stages or CPS functions.[10]

TJJD
As a part of the emergency plans for TJJD facilities and county juvenile facilities, TJJD must ensure there are plans in place for deploying employees to facilities and areas in need. In Giddings,

flooding posed a hardship for staff getting to campus. However, appropriate staffing levels were maintained at the facility by transporting staff via school bus.[11]

Impact on Trauma and Capacity

The effects of Hurricane Harvey regarding the trauma experienced by children and families are unknown. Past studies show child abuse and neglect increase after a disaster or storm. After a disaster, TJJD, CPS, and county staff must provide children with opportunities to talk about what they went through or what they think about it, and encourage them to share concerns and ask questions. Children who have serious emotional and behavioral problems are at high risk for severe stress after a disaster or traumatic event. In many cases, it may help to maintain as much of a normal routine and environment as possible. It is difficult to predict how some children will respond to disasters and traumatic events. Because parents, teachers, and other adults see children in different situations, it is essential that they work together to share information about how the child is coping after a traumatic event. The Legislature invested heavily last session and made significant statutory changes to enhance capacity in the CPS system. The committee will continue to monitor any ongoing impacts of the hurricane on capacity in the CPS system.

Conclusion

In total, the response by both DFPS, TJJD, providers, counties, and other stakeholders was swift, efficient, and resulted in fast action and response. While emergency protocols and evacuation procedures are in place through minimum standards, communication can always be improved for future needs. All state agencies, counties, and stakeholders have been involved since the storm delving into protocols, policies and procedures. The Legislature should oversee necessary changes are made by these state agencies, especially in regards to communication between state agencies, local government, and providers to ensure future storms do not result in preventable workloads and stress for those directly involved in the aftermath of a naturel disaster. Most importantly, data should be tracked by these entities on child outcomes and family outcomes as a result of the storm, to ensure those involved in the child protective system and juvenile justice system are provided appropriate services and supports that minimizes the impact of trauma occurring from Hurricane Harvey.

Recommendations

1. **DFPS should monitor ongoing impacts on capacity including how the storm affects the displacement of children, child specific contracts, and families becoming foster parents.**
   - CPS is surveying providers to determine what the long-term impacts to capacity will be.
   - CPS is working with providers to determine which families were in the process of becoming foster parents in affected areas, but withdrew their application.

2. **DFPS should work with providers including Single Source Continuum Contractors (SSCCs) to develop tracking and reporting mechanisms to have real-time data regarding placements, capacity, and shelter needs.**

3. **TJJD and counties should track and measure potential recidivism of families and youth affected by the storm re-entering the system.**

4. **DFPS and TJJD should ensure all providers have plans in place as a part of their emergency preparedness to have appropriate staff, especially in the instance of a disaster to ensure staff in facilities have relief.**

5. **DFPS should define disaster reporting requirements ahead of time by including them as supplemental contract provisions that kick in when an emergency occurs.**
   - Streamline protocols to ensure all information requested from providers is requested once, in the same format, and expectations are given to providers.
   - Ensure timeframes for information are specified to providers, and that information is disseminated to all necessary DFPS departments and programs.

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List*, November 8, 2017.
[2] Information provided by the Department of Family and Protective Services via Email, October 26, 2017.
[3] Texas Juvenile Justice Department, *Testimony before the Senate Committee on Health and Human Services*, November 8, 2017, page 3.
[4] Texas Juvenile Justice Department, *Testimony before the Senate Committee on Health and Human Services*, November 8, 2017, page 4.
[5] *Supra* Note 2.
[6] Texas Juvenile Justice Department, *Testimony before the Senate Committee on Health and Human Services*, November 8, 2017, page 11.
[7] Information provided by the Department of Family and Protective Services via Email, October 26, 2017.
[8] Harris County Juvenile Probation Department, *Testimony before the Senate Committee on Health and Human Services*, November 8, 2017.
[9] Information provided by the Texas Juvenile Justice Department via Email, October 9, 2017.
[10] *Supra* Note 2.
[11] Texas Juvenile Justice Department, *Testimony before the Senate Committee on Health and Human Services*, November 8, 2017, page 10.

Interim Charge 1C: Disaster SNAP Response

Interim Charge Language*:* *Evaluate the efficiency of the Supplemental Nutrition Assistance Program (SNAP) and the Disaster-SNAP programs following Hurricane Harvey in impacted areas.*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on November 8, 2017. Invited testimony was provided by Wayne Salter, Associate Commissioner for Access and Eligibility Services representing the Health and Human Services Commission (HHSC).[1,2]

Introduction

Individuals affected by Hurricane Harvey lost homes, transportation, food, and were temporarily unable to work. The federal government has programs in place to assist people temporarily and give them an opportunity to recover after a disaster. The purpose of this charge is to review the efficiency of the Supplemental Nutrition Assistance Program (SNAP) and Disaster SNAP (D-SNAP) and to ensure these resources are distributed as efficiently and effectively as possible, and solely for their intended purpose.

SNAP/ D-SNAP Background

SNAP, D-SNAP and Enhanced SNAP are federal nutrition assistance programs for eligible, low-income individuals. Each program has different eligibility, benefits and application processes. SNAP is an ongoing program that offers low-income individuals nutritional assistance. For September 2017, the caseload for SNAP was 1,900,205 households, or 4,619,543 individuals.[3] SNAP benefits are enhanced (Enhanced SNAP) for individuals already receiving SNAP benefits that are affected by a disaster. D-SNAP offers short term food assistance for families affected by a federally-declared disaster who are not recipients of SNAP benefits at the time of the disaster. The chart below, *Income Eligibility and Allotment*, shows income limits and maximum monthly allotments for both programs.[4] Both SNAP and D-SNAP benefits are 100 percent federally-funded, but the costs of administering the programs are shared 50/50 by the state and federal government. The benefits for both programs are distributed through the Lone Star Card which can be used just like a debit card at any store that accepts SNAP.

To receive benefits for D-SNAP and enhanced benefits for SNAP, an individual must be from a county that has been declared a federal disaster area. Counties that were federally designated as disaster counties during Hurricane Harvey (39 total): Aransas, Austin, Bastrop, Bee, Brazoria, Calhoun, Chambers, Colorado, DeWitt, Fayette, Fort Bend, Galveston, Goliad, Gonzales, Hardin, Harris, Jackson, Jasper, Jefferson, Karnes, Kleberg, Lavaca, Lee, Liberty, Matagorda, Montgomery, Newton, Nueces, Orange, Polk, Refugio, Sabine, San Jacinto, San Patricio, Tyler, Victoria, Walker, Waller, Wharton.[5] On October 11, 2017, Caldwell and Grimes counties were added to the federal disaster declaration making the total number of federally declared disaster counties 41, but they did not receive enhanced benefits because the period of need had already passed.

Income Eligibility and Allotment			
Household Size	D-SNAP Net Income Limit	SNAP Net Income Limit	D-SNAP and SNAP Maximum Monthly Allotment
1	$1664	$990	$194
2	$2009	$1335	$357
3	$2354	$1680	$511
4	$2710	$2025	$649
5	$3084	$2370	$771
6	$3458	$2715	$925
7	$3804	$3061	$1022
8	$4151	$3408	$1169
Each Additional Member	+$347	+$347	+$146

Mechanics of D-SNAP

D-SNAP is different from SNAP in eligibility requirements, benefits, and the application process. This section lists the eligibility, benefits, and application process for D-SNAP:[6]

Eligibility

- Be from a county that has been declared a federal disaster area.
- Have experienced an adverse effect as a result of disaster. This could include loss of income, home destruction, or a disaster-related expense, such as temporary shelter or home repairs.
- Not be a recipient of regular SNAP food benefits at the time of the disaster.
- Meet certain income limits (see chart above).
- If you enroll in D-SNAP and you are pregnant or have a child younger than five, you are also eligible for WIC. This allows you to get healthy foods such as fruit and vegetables, cereal, bread and milk, as well as breastfeeding assistance, infant formula and help from nutritionists and other resources.

Benefits

- D-SNAP is a one-time payment loaded on a Lone Star Card within three days of approval for benefits.
- See chart above for what funding a household can receive based on income and household size.
- D-SNAP recipients receive two months' worth of benefits in a one-time payment. (That means a one-person household meeting the income requirements will receive D-SNAP for a total of $388 or $194 per month.)

Application for Benefits

- HHSC's Disaster website, https://hhs.texas.gov/services/financial/disaster-assistance, was updated throughout the disaster relief process to provide information on benefits offered.

- Unlike SNAP, a person applying for D-SNAP must apply in person to ensure the person applying is actually the correct person. The in-person application is a federal requirement.
- Households must bring identification when applying for D-SNAP. Common types of verification include a driver's license or other government-issued photo identification.

Enhanced SNAP Benefits After Harvey

People who already receive SNAP benefits are allowed to receive certain benefit enhancements in times of disasters to give these recipients time to recover. Just like with D-SNAP, a person must live in one of the 39 federally declared disaster counties to receive enhanced SNAP benefits. Below is a list of the benefit and eligibility enhancements for SNAP recipients in disaster areas.

Benefit Enhancements

- SNAP food benefits were increased to the maximum monthly allotment for August and September and were added to the Lone Star Cards in September.
- SNAP recipients were allowed to use their benefits for hot foods and ready-to-eat foods, such as rotisserie chicken or grocery store deli foods, at retailers that accept SNAP until October 31. Normally, hot foods are not allowed through SNAP.
- Recipients were granted benefits on September 1 which was earlier than normal. Usually, funds are distributed throughout the first half of the month. This allowed recipients to use their benefits in case everything was destroyed.
- Recipients saw a percentage of their August benefits automatically added to their Lone Star Cards to replace food lost during Hurricane Harvey.[7]

Eligibility Enhancements

- HHSC requested and received a waiver that allowed the state to auto-extend the certification period for SNAP recipients in the impacted areas for an additional six months. This extension was offered for individuals whose renewal for SNAP was due in August, September or October. Typically, SNAP benefits are limited to three months within a three year period for individuals who are between the ages of 18-49 with some exceptions. Individuals not between the ages of 18-49 are not subject to time limits for SNAP and may receive benefits as long as they meet all other eligibility criteria.[8]

Fiscal impact of SNAP/ D-SNAP

The federal government pays 100 percent of SNAP and D-SNAP benefits, but there is a 50/50 federal and state match for administrative costs related to these benefits. As of November 2018, the total SNAP and D-SNAP benefits issued as a result of Hurricane Harvey totaled more than $769 million all funds. D-SNAP benefits were issued to over 1.6 million individuals, with benefits totaling more than $532 million. Enhanced SNAP benefits include supplemental and replacement benefits. Supplemental SNAP payments were issued to over 1 million individuals, with benefits totaling more than $145 million. SNAP Replacement Benefits were issued to over 1.6 million individuals, with benefits totaling more than $91 million. As of November 2017, HHSC's current estimate for D-SNAP administration costs, including staffing costs, is $16.7 million AF and $8.3 million GR. They federal government notes that this estimate is not final and will increase, as

HHSC and their federal counter parts are still identifying and collecting information on related expenditures.

Issuance of SNAP/D-SNAP Benefits Following Harvey

The enrollment process presented the biggest challenge. The federal government mandates in-person enrollment to reduce fraud, but that requires state and local officials to work together on site selection for enrollment within each jurisdiction. Texas statute designates the county judge as the authority in disaster response; therefore, the county is responsible for identifying D-SNAP sites that HHSC will use to enroll D-SNAP beneficiaries.[9] The sites identified by the county are submitted to the U.S. Department of Agriculture - Food and Nutrition Service (FNS) for final approval.[10] However, in some cases, especially in urban counties, the city controls the large, public facilities that best support in-person D-SNAP enrollment. Therefore, collaboration between county and city officials is critical. HHSC found that in addition to site selection difficulty related to stakeholder collaboration, there was a lack of understanding about the D-SNAP program, requiring HHSC to start at a basic level by educating stakeholders on the mechanics of the program before they could even begin to make a site selection.

Conclusion

Greater collaboration between federal partners and state, county, and city officials will help reduce administrative burdens and ensure these programs are efficient and effective.

Recommendations

1. **Increase collaboration with state, county and city officials to establish awareness and understanding of D-SNAP operations and develop an outreach plan that engages local agencies and the media.** HHSC intends to work with local officials to create a directory of local points of contact. They will also survey these local contacts to determine the best mode of communication. Prior to the start of hurricane season, HHSC will hold webinars, conference calls, and/or in-person meetings with local officials to explain D-SNAP and develop a strategy for effective collaboration. These activities began in March of 2018 and will be repeated in subsequent years.[11]

2. **Work with state, county and city officials to pre-select and evaluate potential D-SNAP sites and maintain a list of those sites with routine review.** Addressing facility/space challenges by establishing Memorandums of Understanding (MOUs) with local agencies before disaster hits will limit any issues with collaboration during an actual disaster.

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List*, November 8, 2017: http://www.legis.texas.gov/tlodocs/85R/witlistmtg/pdf/C6102017110810001.PDF.
[2] Senate Committee on Health and Human Services, *Interim Hearing Minutes*, November 8, 2017: http://www.legis.texas.gov/tlodocs/85R/minutes/pdf/C6102017110810001.PDF.
[3] Information provided by the Health and Human Services Commission via email on October 31, 2017.
[4] Texas Health and Human Services Commission, *Presentation to the Senate Committee of Health and Human Services: Hurricane Harvey Disaster SNAP*, November 8, 2017: https://hhs.texas.gov/sites/default/files//documents/laws-regulations/reports-presentations/senate-hhs-hearing-dsnap-presentation.pdf.

[5] U.S. Department of Homeland Security - FEMA, Texas Hurricane Harvey (DR-4332), September 15, 2017: https://www.fema.gov/disaster/4332.
[6] *Supra* note 4
[7] *Supra* note 4
[8] Information provided by the Texas Health and Human Services Commission via email on October 27, 2017.
[9] Texas Government Code §§ 418.101, .1015, .102, .103, and .104.
[10] *Supra* note 4
[11] Information provided by the Texas Health and Human Services Commission via email on November 11, 2017.

Interim Charge 2A: Family-Based Safety Services

Interim Charge Language: *Review the efficacy and quality of services offered to ensure family preservation while in the Family Based Safety Services (FBSS) stage of service at the Department of Family and Protective Services. Make recommendations to better track quality of services and link payments to providers of these services to outcomes for families and children.*

Hearing Information

The Senate Committee on Health and Human Services hearing was held on March 22, 2018. Individuals representing the Department of Family and Protective Services (DFPS), The Stephen Group, and Pathways Youth and Family Services provided invited testimony.[1]

Background

DFPS provides Family-Based Safety Services (FBSS) and family reunification services to protect children who are at an imminent risk of abuse and neglect, help families reduce the risk of abuse or neglect, and avert the removal of children from their home. These services make it possible for children to return home and live there safely. While the goal of FBSS is to keep families together, in some instances children are removed from the home temporarily while the family completes services.[2] Additionally, while the ultimate goal is to reunify the family after completion of services, almost five percent of children are removed from the home and placed in foster care due to DFPS' determination that the child will only be safe from abuse and/or neglect if removed from the home.[3] Once an FBSS caseworker determines that the family is able to safely care for their child without CPS services, a case is closed. In Fiscal Year (FY) 2017, 35,725 total families were served in the FBSS stage of service, 23,460 families entered FBSS and/or family reunification services and 24,088 families completed services.[4]

While the average length of time for family's to receive FBSS services is six to seven months, only 66 percent of families receive services within the first 30 days of entering FBSS and for 14 percent of families it takes over 60 days.[5] This extends the time CPS is involved in a family's life, extending the time these families must have CPS involved in their lives. Many families who receive substance abuse services through FBSS wait even longer to receive services due an increasing demand for substance abuse services statewide.

Current FBSS Purchased Client Services

The most utilized FBSS services given to families are counseling and substance abuse services.[6] In total, however, FBSS includes an array of services:

Assessment Services (Home Studies)	Assessment services include Kinship Caregiver Home Assessments, Health, Social, Educational, and Genetic History Reports (HSEGH/Adoption Readiness Reports). DFPS purchases and uses assessments to make placement decisions that are in the best interest of the child.
CPS TPASS Drug Testing	Drug testing accessed through a TPASS contract.
Claims Processing	Contracted check writing services for processing payment to persons and entities having delivered goods or services to eligible clients.

Community and Parent Group	Services with councils, associations, and organizations to develop and expand the activities of groups that promote services to abused and neglected children or their caregivers.
Drug Testing	Substance abuse testing for clients when/if the worker has reason to believe the client has a substance abuse problem and the client denies the problem and/or refuses to participate in substance abuse assessment and/or treatment.
Evaluation & Treatment	Services include assessment and evaluation; services include psychiatric and psychological testing and individual, group, and family counseling.
Family Group Decision making	Family group decision making is one method of case planning used to ensure effective permanency plans for children. The service consists of a meeting of parents, other relatives, and close friends of the family to discuss possible relative or fictive placement of the child. The process emphasizes the family's responsibility to care for their children, and encourages families to connect with others who can help support them.
Other	Diagnostic Consultation (SXAB); Fatherhood Project; and Intake Case Management Services
Service Levels System	A system of assessing a child's needs when he/she comes into care with DFPS. Levels of care (basic, moderate, specialized, and intense) determine type of placement and daily childcare reimbursement rate. DFPS staff may authorize Basic level only. For those children who need more than basic care, a third-party contractor must determine level of care.
Substance Abuse Treatment Services	A contract with a Chemical Dependency Treatment Facility (CDTF-Substance Use Disorder (SUD)) or a Licensed Chemical Dependency Counselor (LCDC-Substance Abuse Services (SAS)) providing substance abuse assessment and substance use disorder treatment in the form of individual and group counseling.[7]

Most FBSS services are located in the community, which allows DFPS to refer a family to a specific community organization without utilizing state funds. However, judges can order specific services and require the state to pay for those services.[8]

Increase in Families Receiving FBSS Services

Beginning in September 2015, DFPS rolled out a new assessment known as Structured Decision Making (SDM) in all CPS investigations to determine the level of risk for recidivism, thereby determining if a family needed to receive FBSS services.[9] This uniform assessment ensures every family receives an unbiased assessment of their risk level and need for services. Since this tool has been implemented, there has been an increase in the number of FBSS cases opened and an increase in recidivism for families that received FBSS services within the last year. For example, in FY 2016, recidivism rates within twelve months after a FBSS case was closed was 7.6 percent and in FY 2017 it was 10.3 percent.[10]

To address recidivism of those families receiving FBSS services, beginning in July 2015, CPS required a specialized FBSS Quality Assurance team of Child Safety Specialists to review FBSS cases identified as very high risk of severe recidivism during the open FBSS stage. Severe recidivism refers to a subsequent confirmed allegation of physical or sexual abuse, a case that ended in a fatality, or a case that resulted in the removal of the child from the home. Examples of

risk factors that would qualify a case as very high risk include families with very young children, families in which a child was born addicted or exposed to drugs or alcohol, or families with a prior history of abuse. While a 2015 pilot of this program showed a 34 percent decrease in recidivism in the San Antonio area, recidivism of abuse and neglect for families that have received FBSS services has continued to increase since implementation of these case reviews, as well as the total number of families that receive FBSS services. [11]

Current FBSS Performance Outcomes

In 2014, the Sunset Advisory Commission conducted a review and assessment of the FBSS program and how it provides Purchased Client Services (PCS). The Commission recommended that DFPS develop more specific outcome measures for PCS by tracking the effectiveness of contracted services and service providers, and to ensure FBSS caseworkers are referring families to the right services. [12]

In response, Senate Bill 11 (85R) requires DFPS to work with a higher education institution to revamp FBSS performance outcomes. DFPS requires various performance measures for different types of FBSS services, but these measures are output focused as opposed to outcome focused. [13]

Concerns with the FBSS System

During the 2014-2015 Sunset review of DFPS it became increasingly clear that there are many unknowns with the current FBSS services offered to families. For example, it became obvious that in many cases, caseworkers are not being communicated to about contracts DFPS has with external providers, so those providers do not always receive referrals. In addition, it was reported that caseworkers sent families to certain providers based on word-of-mouth from other caseworkers as opposed to utilizing reliable, high-quality providers. Few evidence-based programs are utilized statewide, and there is insufficient data to determine the effectiveness of services provided in this program. The 2015 Stephen Group Report summarized that certain areas of the state lack specialty providers, such as substance abuse treatment or therapy services. Finally, it was revealed that only 62 percent of families completed at least one of the services they were required to complete through FBSS. This low completion rate not only signifies potential lack of family engagement, but also that services may have been delayed, or difficult to obtain due to a lack of specialty services in a family's geographical area. [1415]

FBSS Pilot Program

To address the concerns above, the 85th Legislature passed Senate Bill 11, which directs DFPS to contract with an external community entity to provide FBSS services in two regions statewide.[16] In response, DFPS contracted with Pathways Youth and Family Services to assume responsibility for providing case management to families that receive FBSS in Region 10 (El Paso). This includes developing a full array of services to meet the needs of these children and families. The goal of the pilot is to improve the array of evidence-based services provided, reduce recidivism of families re-entering the CPS system, and reducing the length of time families are involved in the FBSS stage of service. The pilot began in March of 2018 and initial performance outcomes should be available at the beginning of the 86th Legislative Session. [17]

Pathways Youth and Family Services has defined success of this pilot program as reducing the length of time children and families are receiving services to under 140 days or four to five months;

reducing recidivism below 7 percent (the statewide average is still around 10 percent); providing 70 percent of FBSS in home versus out of home or clinical; and improving family engagement which includes completion of services. [18]

Since this pilot is still new and a second pilot area required in Senate Bill 11 has not yet been determined, it is difficult for the Legislature to act in response to the results of the new care model. However, it is clear that the current FBSS structure is in need of reform. While changes have been made to FBSS, continued work is needed, especially as the population of families involved in FBSS continues to grow.

Recommendations

1. **The Legislature should review outcomes from the FBSS pilot in El Paso and consider other pilot program areas to fund in the 86th biennium.**
   Specifically, the Legislature should look at recidivism between families served in the piloted areas as opposed to the legacy system.

2. **The Legislature should monitor DFPS' oversight of the FBSS pilot programs, specifically that the DFPS implements monetary incentives and disincentives for failing to meet contractual performance measures.**

3. **Senate Bill 11 (85R) calls for DFPS to revamp performance outcomes for FBSS. These new performance metrics should be added to contracts in January of 2019. The Legislature should monitor, review, and discuss these new performance outcomes with stakeholders.**

4. **The capacity and plethora of FBSS services statewide is largely unknown. DFPS should conduct a needs assessment for these services similar to the capacity needs assessment required in Senate Bill 11 (85R).**

5. **The Families First Act has the potential to utilize federal funds for FBSS services that are funded by General Revenue currently. The Legislature and DFPS need to weigh the benefits and costs of utilizing this new funding source.**

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List*, March 22, 2018.
[2] Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, March 22, 2018.
[3] Information provided by the Department of Family and Protective Services via email, October 30, 2018.
[4] Information provided by the Department of Family and Protective Services via email, March 7, 2018.
[5] *Supra* Note 4
[6] Information provided by the Department of Family and Protective Services via email, March 16, 2018.
[7] The Stephen Group, *Family-Based Safety Services Assessment*, November 2015.
[8] *Supra* Note 2
[9] *Supra* Note 4

[10] Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, March 22, 2018, page 8.
[11] Information provided by the Department of Family and Protective Services via Email, July 29, 2016.
[12] Sunset Advisory Commission, *Department of Health and Human Services Staff Report with Final Decisions*, Chapter 4, July 2015.
[13] Senate Bill 11, 85th Regular Session (Schwertner, Frank, 2017.)
[14] *Supra* Note 7
[15] *Supra* Note 12
[16] *Supra* Note 13
[17] Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, March 22, 2018, pages 10 and 11.
[18] Pathways Youth and Family Services, *Testimony before the Senate Committee on Health and Human Services*, March 22, 2018.

Interim Charge 2B: Timely Investigations

Interim Charge Language: *Analyze the Department of Family and Protective Services' progress in meeting statutory requirements related to timely visits to children involved in a reported case of abuse or neglect. Make recommendations to further improve the timeliness of these visits.*

Hearing Information

The Senate Committee on Health and Human Services hearing was held on March 22, 2018. Individuals representing the Department of Family and Protective Services (DFPS) provided invited testimony.[1]

Introduction and Background

In 2016, the Department of Family and Protective Services (DFPS) was in the midst of a crisis. Children at risk of abuse and neglect were being left unseen by an investigations caseworker for days and weeks past the statutory guidelines put in place by the Texas Legislature. In addition, some children were not being seen at all. To address this, the Legislature stepped into action in late 2016, to increase DFPS caseworker pay and add additional direct care staff, particularly in the investigations division, to ensure all children who had a threat of abuse or neglect were seen in a timely manner to ensure their safety and protection.

Section 261.301 of the Texas Family Code requires a 24-hour response from DFPS to a report of abuse or neglect that involves circumstances in which the death of the child or substantial bodily harm to the child would result unless the department immediately intervenes. Children that are deemed by DFPS to be at substantial risk of harm or death are classified as a "Priority One" investigations, requiring a 24-hour response.[2] This requires a DFPS investigations caseworker to physically see a child and ensure either the child is safe in their home, or must be removed in order to prevent additional abuse and neglect from occurring. In addition this section of statute requires all other children not classified as "Priority One" to be seen within 72-hours after DFPS receives an intake. These children and families fall under the category of a "Priority Two" investigation and response protocol.[3]

On October 17, 2016, DFPS reported a statewide total of 2,844 children named in abuse allegations that had not been seen, and of that, 511 were classified as a "Priority One" investigation. Fifteen thousand children were not contacted within the required statutory guidelines set forth by the Legislature, and 2,000 were classified as a "Priority One" investigation.[4]

Legislative Response

To address this dire need, the 85th Texas Legislature funded 829 new positions at DFPS, with a large portion of the new positions occurring in the investigations division.[5] In addition, a $12,000 raise was given to "front-line" staff for the investigations, conservatorship, and family-based safety services workers in addition to salary increases for many other CPS employees[6] As a result of actions made by the Legislature, in addition to newly implemented policies and procedures at DFPS, timeliness of "Priority One" investigations increased from 74.3 percent statewide in January of 2017, to 86.6 percent by August of 2017. Similarly, "Priority Two" investigations increased from 68.5 percent in January of 2017 to 86 percent in August 2017.[7] During the 85th

Legislative Session, the Legislature continued the initiative of funding additional employees at DFPS and the additional salary increase that was funded in December of 2016. As a result, in August of 2018, 90.7 percent of "Priority One" cases and 89.4 percent of "Priority Two" cases were seen within the required statutory timeframes.[8]

Future Efforts Needed

With the positive impact seen in investigations, children under conservatorship of the state as well as children and families who receive Family-Based Safety Services (FBSS) from DFPS are and continue to be a central issue the Legislature should continue to address. Federal requirements already ensure children are seen on a monthly basis, and in 2017, 98.6 percent of children were seen monthly that were under conservatorship of the state.[9] This must continue to be overseen by the Legislature to ensure all children are safe while in state care.

In addition, children and families receiving Family-Based Safety Services (FBSS) are required by DFPS policy to be seen monthly. Until 2015, DFPS policy required more than monthly visits, such as bi-monthly or weekly visits, depending on the potential risk of abuse and neglect to the children in that household.[10] Families who receive FBSS services are considered at imminent risk of a child in their home entering the foster care system, and therefore these families must receive additional oversight in many cases to ensure children remain in the home with their biological families when it is in the best interest of the child. DFPS and the Legislature should evaluate the need for statewide policy regarding timeliness of visits and number of visits for these families to ensure all children who are involved with the Child Protective Services (CPS) system remain safe, whether in their home or in the care of the state.

Recommendations

1. **Implement statutory timeframes for investigations of abuse and neglect in substitute care that match the timeframes of investigations of abuse and neglect in biological homes.**
   DFPS requires the same timeframes for an investigation of abuse or neglect for children in conservatorship that it does for children investigated in their biological home. However, these timeframes are not in statute for children in conservatorship. In addition, DFPS does not readily track this information to ensure investigations occur within the timeframes laid out in agency policy.

2. **Implement statutory timeframes to ensure all children in conservatorship are required to be seen monthly.**
   While this is currently an agency policy, it is not in statute. This would allow the Legislature to more readily receive this data and have sufficient oversight to ensure all children in the CPS system are seen regularly.

3. **The Legislature and DFPS should look at past agency policy which requires families and children in FBSS to be seen at various timeframes depending on the potential risk of the home, and update agency policy as necessary to ensure children and families remain safe.**

FBSS services are a vital part of the CPS system, and help ensure children are not unnecessarily removed from a home. However, safety in the home must continue to be the utmost concern, and families that are at a greater risk of abuse or neglect to children in that home should be monitored more closely to ensure that child can continue to remain with his or her family instead of being placed into substitute care.

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List,* March 22, 2018.
[2] Department of Family and Protective Services, *Testimony before the Senate Health and Human Services Committee,* March 22, 2018.
[3] *Supra* note 2.
[4] Department of Family and Protective Services, *Testimony before the Senate Finance Committee,* October 26, 2016.
[5] Department of Family and Protective Services, *Testimony before the Senate Finance Committee,* December 5, 2017.
[6] Legislative Budget Board, *Testimony before the Senate Finance Committee,* December 5, 2017.
[7] *Supra* Note 6.
[8] *Supra* Note 6.
[9] Information provided by the Department of Family and Protective Services via email, March 15, 2018.
[10] *Supra* Note 9.

Interim Charge 2C: Youth Preparedness

Interim Charge Language: *Review services and supports provided to children in Permanent Managing Conservatorship of the state, and the level of preparedness given to youth aging out of state care. Examine the impact of recent legislation related to these populations, and make recommendations to ensure youth in care are ready for adulthood and to reduce the likelihood of intergenerational perpetuation of child maltreatment.*

Hearing Information

The Senate Committee on Health and Human Services hearing was held on March 22, 2018. Individuals representing Child Protective Services (CPS), the Texas Network of Youth Services, and LifeWorks provided invited testimony.[1]

Background

In extremely unfortunate circumstances, the state has to assume the role of parent for children who have been victims of abuse and/or neglect. However, the state is not a loving, nurturing parent, and therefore attempts to enforce policies to ensure children in conservatorship of the state receive a normal childhood experience and are prepared to enter adulthood whether they are adopted, returned to their families, or age out of foster care. There are several policies, procedures, and programs in place attempting to ensure children and youth in foster care are ready to enter adulthood; however, additional reform is needed.

Youth Exiting Care

Approximately six percent of youth in Texas age out of care, or around 1,100 to 1,200 youth a year, which is below the national average of eight percent.[2] A nationwide survey conducted of children who age out of care found that at age 19, 20 percent of youth who age out of care are homeless, 20 percent are in prison, and ten percent have a child.[3] It is also known that youth who age out of care tend to have longer stays in foster care and more placements within care, greater vulnerability to homelessness, trafficking, unemployment, mental health and substance abuse issues, and post-traumatic stress.[4] These numbers are alarming, and demonstrate a need to ensure foster care youth have the tools necessary to succeed in society.

Preparation for Adult Living (PAL) Program

Children in the conservatorship of the state have many individuals involved in their daily, weekly, and monthly lives, including planning services and supports they will receive, providing a placement and home for them to stay, and ensuring they have the life skills when they exit foster care.

From the moment a child enters care, they are assigned a conservatorship caseworker who assists with the transition plan for the child when they are leaving care, sets up permanency meetings for the child, and ensures the plan of service for the child while in care is individualized and catered to the child's specific needs. That caseworker alongside the foster parent and providers are supposed to ensure the child receives a normal childhood experience and is appropriately prepared for adulthood. Due to passage of Senate Bill 1758 (Zaffirini, 85R), DFPS ensures every child 14 and older receives a Preparation for Adult Living (PAL) caseworker so that each youth receives an annual life skills assessment and the ability to take a life skills training to prepare them for life

after foster care. This life skills assessment involves a readiness review for a child to live independently, and it is utilized to develop an individualized plan to prepare each child for future independence.[5]

The PAL training is an opportunity for youth ages sixteen to eighteen in foster care to attend and learn different life skills in preparation for adulthood. These trainings cover topics such as job readiness, housing and transportation, financial management, relationships, health and safety, and general life decisions. Trainings are provided by local contractors that partner with DFPS, and provide classroom-like trainings to these youth. Contractors are responsible for providing updates to each child's PAL caseworker for ultimate review by the caseworker. In order to garner youth participation, incentive payments for youth to participate in the PAL program include a transitional living allowance of up to $1,000 which is distributed in increments of up to $500 per month for young adults up to age 21 to assist with initial start-up costs in adult living.[6] Senate Bill 1758 also requires DFPS and stakeholders to develop a plan, and submit that plan by December 1, 2018, to make recommendations for restructuring the PAL program curriculum to ensure youth enrolled in PAL receive relevant and age-appropriate information and training.[7]

For those who participated in PAL, aftercare room and board assistance as well as case management services for youth aged 18-21 is available based on need of up to $500 per month, not to exceed $3,000, for rent, utilities, food, etc. However, passage of federal legislation earlier this year, known a the "Families First Act," extends this assistance to youth up to age 23 if states choose to expand the eligible population for PAL services.[8] Eligible youth who participate in PAL had been hovering around 75 percent of all youth eligible in foster care, but beginning this year, DFPS put increased resources and attention on the PAL program, and now over 90 percent of youth are participating in PAL in 2018.[9]

Documents Given

To prepare youth for adulthood, DFPS ensures all youth age 16 are given a Certified copy of their birth certificate, Social Security card or replacement Social Security card, as appropriate, and personal identification certificate issued by the Texas Department of Public Safety (DPS). At age 18, all youth are to be provided with their immunization records, medical information, proof of Medicaid enrollment, and a medical power of attorney document.[10]

Health Coverage

All youth who age out of care continue to receive Medicaid benefits through STAR Health until age 20, and after receive Medicaid coverage through STAR until age 25. To renew annual Medicaid coverage for these youth, HHSC attempts to renew a young adult's benefits based on information already provided. However, youth that receive this benefit tend to move frequently. A renewal letter will be mailed 3 to 4 months before benefits end in an envelope marked "Time Sensitive" with 10 days to respond. If more than 30 days pass without a response, benefits may end or there may be a gap in healthcare coverage. It is up to the former foster youth to submit annual enrollment document to continue to receive coverage up until age 25.[11]

Educational Support

College Tuition and Fee Waiver

This program provides exemption from tuition and fees at Texas state supported colleges, universities, and technical schools to youth enrolled in college no later than their 25th birthday. Eligible youth must have been in Permanent Managing Conservatorship (PMC) or have been adopted with certain qualifications. Utilization of this waiver has been increasing for eligible adoptive youth over the past few years, but decreasing for foster youth. While 3,704 foster youth utilized this in 2012 compared to only 3,175 in 2016, we have experienced an increase use of by adoptive youth; 829 in 2012 compared to 1,694 in 2016.[12] DFPS does not track the exact number of youth eligible for this waiver, making it difficult to track progress.

Education Training Voucher

This federally funded program gives eligible youth age 16 to 23 up to $5,000 per academic school year to use for housing and other financial needs while attending school. The "Families First Act" gives states the option to expand this program to age 26, but does not allow the participant to utilize this program for more than five years.[13]

Temporary Housing Assistance

Texas' state supported higher education institutes are required to assist full-time students formerly in DFPS conservatorship to locate temporary housing between academic terms.[14]

College Foster Care Student Liaisons

Each state supported college/university has an appointed foster care student liaison to help foster care students in coordinating college readiness and student success.[15]

Housing Options

Extended Care/Return to Care

This is a voluntary program for youth ages 18 to 22 to remain in foster care if they are in school, employed, in an employment program, or have a documented medical condition that makes them incapable of obtaining work or school. Some youth choose to leave foster care for a trial independence of six to twelve months, and re-enroll in extended foster care if they decide to return.[16] In Fiscal Year (FY) 2017, 608 youth were in extended foster care, or about 53 percent of youth that were eligible for this placement.[17]

Supervised Independent Living (SIL)

There are eleven SIL facilities statewide in addition to SIL apartment settings. SILs are a housing option for extended foster care that allows young adults to live independently with minimum supervision provided by a DFPS contracted provider. A youth living in a SIL receives case management services and has additional responsibilities such as managing his or her finances, running errands, and more.[18] In FY 2018 there are 232 youth living in a SIL placement, and it is reported by providers that there is difficulty finding apartments that will accept the SIL rate resulting in youth remaining on the waitlist for an apartment.[19]

Transition Centers

Transition centers provide employment assistance, educational support, access and referrals.

Currently there are 18 transition centers statewide that receive no state funding, but are operated by partnerships between DFPS, providers, community partners, and the Texas Workforce Commission (TWC).[20]

While housing options exist for youth aging out of care, the lack of SILs available for youth should be examined. Because SILs provide greater independence for youth and therefore more appropriately prepare them for adulthood, this option for youth is vital to success after foster care, and ensuring youth have the necessary skills to live and work independently.

Recommendations

1. **The Legislature should review Senate Bill 1758 report which will be released in December 2018 before entering the 86th Legislative Session to consider a potential need to restructure PAL services and supports for youth in foster care.**

2. **DFPS should consider collecting data on the Tuition and Fee Waiver program, specifically on how many youth are eligible for the program, aware of the program, and utilize the program.**

3. **DFPS and the Legislature should consider expanding opportunities for housing options and resources for youth aging out of care.**

4. **The Legislature and DPFS should review the potential for federal funding streams to fund PAL and transitional living services, and consider the implications of expanding the eligible pool of youth eligible for these programs.**

5. **HHSC, DFPS and the Legislature should examine how former foster youth are notified about the need to re-enroll in Medicaid annually.**

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List*, March 22, 2018.
[2] Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, March 22, 2018.
[3] Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, March 22, 2018, slide 3.
[4] National Youth in Transition Database, *Highlight from the NYTD survey: outcomes reported by young people at ages 17, 19, and 21*, November 2016.
[5] *Supra* note 2.
[6] Information provided by the Department of Family and Protective Services via in-person meeting, January 25, 2018.
[7] Senate Bill 1758, 85th Regular Session (Zaffirini/Turner, 2017).
[8] Families First Prevention Act of 2018, HR 1892, 115th Congress., 2nd Session (2018).
[9] Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, March 22, 2018, slide 7.
[10] Texas Department of Family and Protective Services, Personal Documents, retrieved from: https://www.dfps.state.tx.us/Child_Protection/Youth_and_Young_Adults/Transitional_Living/personal_documents.asp.
[11] Texas Department of Family and Protective Services, Medical Benefits, retrieved from: https://www.dfps.state.tx.us/Child_Protection/Youth_and_Young_Adults/Transitional_Living/medical_benefits.asp.
[12] Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, March 22, 2018, slide 9.
[13] *Supra* note 8.

[14] *Supra* Note 6.
[15] *Supra* Note 6.
[16] *Supra* note 2.
[17] Information provided by the Department of Family and Protective Services via email, October 24, 2018.
[18] *Supra* note 2.
[19] *Supra* Note 17.
[20] Information provided by the Department of Family and Protective Services via email, October 30, 2018.

Interim Charge 2D: Foster Parent Recruitment and Retention

Interim Charge Language: *Assess the effectiveness of public and private agency efforts to recruit and retain foster parents. Identify barriers to entry and obstacles that prevent interested families from continuing to provide foster care. Recommend solutions to increase foster recruitment and address non-renewals, especially in first-time foster parents.*

Hearing Information

The Senate Committee on Health and Human Services hearing was held on March 22,2 2018. Individuals representing the Department of Family and Protective Services (DFPS), The Texas Network of Youth Services (TNOYS), and LifeWorks provided invited testimony.[1]

Background

The need for capacity in the foster care system is a long-standing issue in the Child Protective Services (CPS) system. However, in recent years, the number of children entering the CPS system has increased, outgrowing the number of children exiting the system. In 2017, there were 19,782 removals in investigations, but only 18,851 children exited care.[2] This has led to an overburdened foster care system in Texas, which continues to need additional foster homes and placement options for this increasing vulnerable population.

There has been both a national and statewide movement to ensure children are placed in a least restrictive setting, preferably in a home-like setting. DFPS has taken steps over the past years to find relatives for as many children as possible who enter the foster care system in order to place them in relative's homes as opposed to non-family settings. The number of children in kinship homes has continued to increase, with approximately 45 percent of children currently being placed with relatives as opposed to 39 percent in 2012.[3]

Over the past few years, the Legislature has taken a strong lead in facilitating collaborations and partnerships with faith-based entities to recruit and support foster parents, as well as implement a number of policies and programs to increase capacity in the foster care system. Collaborative efforts such as faith-based summits and the funding of faith-based specialists at DFPS has encouraged partnerships with churches and other entities to support kinship and foster families, increasing overall capacity.

Additionally, during the 85th Legislative Session, the Legislature took steps to address this capacity crisis and to ensure children are staying in a least restrictive setting. This included both statutory and budgetary changes that are already producing positive effects for DFPS.

Foster Parent Recruitment

Over 90 percent of foster homes are with private Child Placing Agencies (CPAs), resulting in the majority of foster parent recruitment and outreach is done by private providers, not by the state. Local outreach is done by these providers through partnerships with faith-based entities and nonprofit groups. CPS also has a small amount of its own foster and adoptive homes. DFPS does not track the recruitment efforts of these providers or gather data on how these providers recruit foster families. However, in May of 2017, DFPS sent a survey to obtain information on this topic. Specifically, of the 78 providers who answered the survey, 75 percent of them track how their

foster parents are obtained. Of these providers, over 41 percent of their foster parents come from faith-based efforts.[4]

Foster Care Redesign/Community Based Care

In 2014, Texas moved to a new model of care known as Foster Care Redesign. This model is a community-based approach to care that has resulted in an increase in foster homes in the redesigned area. Because this model gives local providers greater responsibility and accountability over the provision of care to foster children, this model has garnered increased community buy-in to take care of foster children in their community. Foster Care Redesign rolled out in the Arlington area in July of 2014. Within three years, the number of foster homes in the region had increased by 31 percent.[5] This was due to the provider of Foster Care Redesign, ACH Child and Family Services, conducting monthly recruitment events, utilizing the local media, giving presentations to the Rotary Club, Mental Health Connection meetings, and more. At the same time, ACH enlisted a limited number of providers to provide services and on-site training to families in Palo Pinto. ACH knows the community it serves, and because of that, is able to more easily partner with local nonprofits and community groups to increase the number of foster family homes.[6]

In addition, ACH realized the need not only to recruit foster parents, but also to retain tenured foster parents. In response to this, ACH established a foster parent support group to provide ongoing support to retain quality parents and connected church leadership groups with training resources to help them develop foster care ministries.[7] Finally, because ACH has contracts and relationships with other foster providers in the area it serves, ACH is able to coordinate recruitment efforts between all CPAs in the region and provide communication and collaboration between these entities on best practices.

Faith-based Initiative

In addition to reforming the foster care model, Texas is making a concerted effort toward partnership with local entities to recruit and retain foster parents. Beginning in 2016, DFPS, the First Lady of Texas, and the Lieutenant Governor made a strong push for collaboration with faith-based entities, specifically to recruit and retain foster and adoptive parents. In response, in November 2016, DFPS held a one-day Faith Leaders' Summit at the Texas Capitol during which breakout sessions and informational discussions occurred over best practices and how the state can collaborate with faith-based organizations statewide. After this event, local communities have held their own faith-based summits, and DFPS continues to grow partnerships with faith-based entities to recruit foster parents, provide services and supports to current foster parents, as well as help the families and children who interface with CPS. In the past year DFPS has grown faith partnerships by 39 percent. As of January 2017, DFPS was working with 732 churches and have 1,017 church partners engaged in some activity.[8] These different partnerships include one-time events and donations, support of children and families across the continuum, and foster/adopt ministries to recruit and support families.

The goal of those at DFPS is to provide initial opportunities for faith-based organizations to get more involved, in whatever capacity that might look like. While DFPS continues to partner with new churches and faith groups, it does not track to the fullest extent how these partnerships affect the foster care system. Linking these partnerships directly to recruitment and retention of foster

parents should be a goal of DFPS and the Single Source Continuum Contractors (SSCCs) that partner with the state.

Recommendations

1. **Require DFPS to gather and analyze data on how capacity building efforts by DFPS as well as provider capacity efforts are affecting capacity regionally and statewide.**

2. **Require SSCCs to track annual recruitment efforts, and provide that information to DFPS and the Legislature.**

3. **Require all SSCCs to implement a foster parent feedback process to ensure these families are heard, and their needs are addressed and research ways to retain foster parents such as a new foster parent mentor program.**

4. **SSCCs should promote the use of trauma-informed practices.**

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List,* March 22, 2018.
[2] Department of Family and Protective Services 2017 Data Book.
[3] Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services.* March 22, 2018.
[4] Information provided by the Department of Family and Protective Services via email, March 16, 2018.
[5] ACH child and family services, *Testimony before the Senate Committee on Health and Human Services* September 12, 2018, page 2.
[6] ACH child and family services, *Testimony before the Senate Committee on Health and Human Services,* September 12, 2018.
[7] ACH child and family services Progress Report, Foster are Redesign in Texas Region 3b, July 2016, page 19.
[8] *Supra* Note 4.

Interim Charge 3: Substance Use Disorders

Interim Charge Language: *Review substance use prevention, intervention, and recovery programs operated or funded by the state and make recommendations to enhance services, outreach, and agency coordination. Examine the adequacy of substance use, services for pregnant and postpartum women enrolled in Medicaid or the Healthy Texas Women Program and recommend ways to improve substance use related health outcomes for these women and their newborns. Examine the impact of recent legislative efforts to curb overprescribing and doctor shopping via the prescription monitoring program and recommend ways to expand on current efforts.*

Hearing Information

The Senate Health and Human Services Committee held a hearing on March 22, 2018 to discuss Interim Charge 3. Individuals representing the Health and Human Services Commission (HHSC), the Texas Hospital Association (THA), the Texas Association of Substance Abuse Providers (TASAP), Meadows Mental Health Policy Institute, Bluebonnet Trails Community Services, the Texas Association of Health Plans (TAHP), the Texas Medical Association (TMA), and the Texas Pharmacy Board (TPB) provided invited testimony.[1]

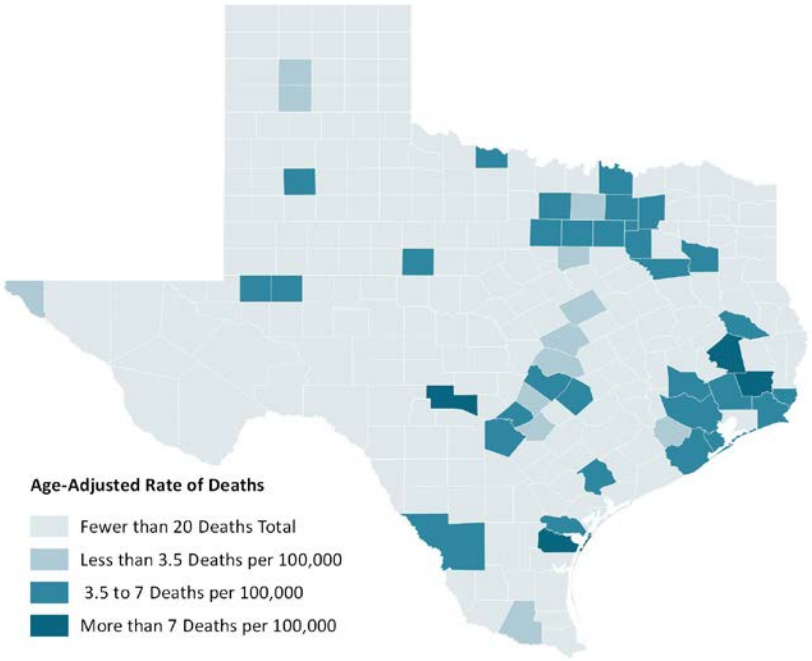
Introduction

A Substance Use Disorder (SUD) is a pattern of harmful, continued substance use that causes significant impairment, affecting 1.6 million adult Texans. A majority of youth and almost half of adults with SUDs live below 200 percent of the Federal Poverty Line (FPL). [2] While many people use substances, a small percentage meets the diagnostic criteria for having a SUD. Most are related to alcohol, but about one in five are drug-related.

A majority of Texans with a SUD do not receive any treatment. [3] Of the population potentially eligible for state-funded services, only six percent of adults and five percent of youth accessed services in 2014.[4] The capacity of the state's behavioral health system is a major challenge to providing treatment, mostly due to workforce and bed shortages. Further, while severe SUD is known to be a chronic condition, much of the treatment provided is episodic, targeting short-term impairment. Without access to continued treatment, those with severe conditions are more likely to relapse.[5] Overdoses drive emergency room utilization and are the leading cause of maternal deaths in the state.[6] Beyond health-related effects, substance abuse is a leading contributor of families entering the Child Protective Services (CPS) system or individuals entering the criminal justice system.

Opioids, both prescription drugs and heroin, kill over 1,000 Texans per year. Fatal overdose rates vary substantially by region, as seen in the map below. Prior to 2015, a majority of opioid-related deaths involved commonly-prescribed opioids. However, in 2015, heroin resulted in the most deaths (516 deaths).[7] Recent data indicates that highly potent and dangerous synthetic opioids, such as Fentanyl, have started to appear in Texas.[8] Methamphetamine is also a serious and rising threat, causing 715 deaths in 2016, the highest reported of any substance.[9]

Age-Adjusted Opioid Related Deaths by County, 2011-2016[10]



The Texas Response

- Many of the state's recent efforts to address SUDs have been focused on prescription opioids. Recent improved prescription monitoring has been associated with a slower growth rate in deaths related to opioids through discouraging overprescribing and identifying doctor shopping patterns. However, deaths due to heroin have risen during this period, raising concerns that individuals may be switching from prescriptions to illegal sources.[11]

- Congress enacted the 21st Century Cures Act in 2016, which made one billion dollars available to states to fight the opioid crisis in the form of grants from the Substance Abuse and Mental Health Services Administration (SAMHSA). Texas was awarded $27.4 million per year in grants for the 2018-2019 biennium. This grant is known as the Texas Targeted Opioid Response (TTOR) grant.[12] In October 2019, the state was awarded an additional $46.2 million to expand access to opioid treatment and recovery support services, including medication-assisted treatment.[13]

- The 84th Legislature granted the Department of State Health Services (DSHS) an Exceptional Item request for $11.2 million in additional funds in the 2016-17 biennium. The Exceptional Item supports new and existing services aimed at reducing the incidence and severity of Neonatal Abstinence Syndrome (NAS) in the state. This funding was maintained by the 85th Legislature.

- The 85th Legislature passed House Bill 13 and Senate Bill 292. These bills created two behavioral health grant programs to address gaps in services at the local level, including SUD services.

Co-Occurring Mental Health Conditions

At least one-third of adults and one-fourth of youth with SUDs in Texas have a co-occurring mental illness. While many treatment services address one disorder at a time, best practices indicate treatment of psychiatric disorders and SUDs should occur simultaneously. According to SAMHSA, there is a higher prevalence of co-occurring disorders among veterans, homeless individuals, and justice-involved populations.[14] Charlie's Place Recovery Center in Corpus Christi, which served 2,079 patients in Fiscal Year (FY) 2017, testified that 55-60 percent of their patients have co-occurring mental health disorders. The center primarily treats SUDs, and refers patients to other services for mental health treatment.[15] No data exists on actual capacity for co-occurring disorders, but behavioral health programs should prioritize the integration of services for co-occurring mental health conditions and SUDs.

Access to treatment

Individuals with SUDs face several challenges in accessing treatment services. These include provider shortages, waiting lists for services, and the common misconception by medical professionals and the public that an individual's mental health needs take priority over SUD needs, when both should be treated at the same time. Untreated SUDs drive crisis and emergency room utilization, resulting in an estimated $350 million per year in emergency room charges. The vast majority of adults in need receive no SUD treatment.[16]

Point of Entry--Outreach, Screening, Assessment & Referral (OSAR)

There are 14 OSAR agencies at Local Mental Health Authorities (LMHAs). These are one, but not the only, front door to SUD services for indigent people. OSARs provide outreach, screening, and assessment to people to determine their need for SUD services, and make referrals to services in the most appropriate and available setting. OSARs receive approximately $7 million in annual funding and serve approximately 30,000 people annually.[17]

HHSC Non-Medicaid Indigent Care Programs

The legislature appropriated $177 million for indigent SUD services for FY18, with 76 percent coming in the form of federal grants. Individuals ineligible for Medicaid whose adjusted income is below 200 percent of the FPL can receive fully-funded treatment and recovery services through HHSC. For individuals above 200 percent FPL, fees are assessed on a sliding scale. Just under 35,000 adults and 4,500 youth received SUD services through this system in 2016.[18] The following chart shows the array of services and programs[19]:

Service Array	Program
Prevention	• Youth prevention education • Prevention Resource Centers • Community Coalition Partnerships
Intervention	• Outreach, Screening, Assessment, and Referral • Pregnant and Postpartum Intervention • Parenting awareness and Drug Risk Education • Rural Border Initiative • HIV Outreach • HIV early education
Treatment	• Adults: Detox, Residential, Outpatient, Specialized Women, Medication Assisted, Co-Occurring, HIV Residential • Youth: Intensive Residential; Supportive Residential, Outpatient
Recovery	• Recovery Support Services • Peer Support and Peer Recovery Services
Initiatives	• Neonatal Abstinence Syndrome • Strategic Prevention Framework for Prescription Drugs • Texas Target Opioid Response • First Responders--Comprehensive Addiction Recovery Act • Statewide Youth Treatment Implementation • HB 13 Community Mental Health Grant Program • SB 292 Mental Health Grant Program for Justice-Involved Individuals

Medicaid SUD Benefit

The state created the Medicaid SUD benefit in 2010. Adults and children with Medicaid coverage can receive comprehensive treatment services including outpatient services (assessment, ambulatory detoxification, individual and group outpatient counseling, medication-assisted treatment), and residential services (treatment and detoxification). Just under 6,000 adults received Medicaid-funded SUD treatment in FY15, with treatment costs totaling $9.7 million. This benefit has had a positive impact on reducing Medicaid spending associated with untreated SUD. The agency's benefit evaluation report required by the 85th Legislature found that in FY15, the average cost per treated client with SUD was $12,003 while the average cost per un-treated client with SUD was $13,075.[20]

Funding

Total SUD funding for the 23 agencies represented in the Statewide Behavioral Health Coordinating Council is shown below. A majority of federal funding for SUD comes in the form of Substance Abuse Prevention and Treatment Block Grants (SABG) from SAMHSA. HHSC, The Department of Family and Protective Services (DFPS), and the Texas Department of Criminal Justice (TDCJ) receive the most funding.

Total SUD funding FY18-FY19[21]

Funding Type	FY 2018	FY 2019
General Revenue	$228,302,008	$233,048,425
Federal Funds	$312,993,652	$312,993,652
Interagency Contract	$1,136,447	$1,136,387
Other	$3,9697,275	$18,632
TOTAL	**$546,399,382**	**$547,197,096**

Provider workforce and capacity

Texas has a serious shortage of SUD providers. Compared to other states, Texas has the third lowest ratio of providers, at 17.7 per 1,000 adults with a SUD. The national average is 32.1 per 1,000.[22] One of the main factors contributing to the shortage is low provider reimbursement rates given the extensive education required to enter the field.[23] House Bill 3083 (85R) added licensed chemical dependency counselors to the list of mental health professionals eligible for the Mental Health Loan Repayment Program, but more efforts are needed to attract and retain providers.[24]

Certified Peer Specialists are also part of the SUD workforce. Peer support is an evidence-based practice where peers use their lived experiences recovering from mental illnesses or SUDs and skills learned in formal training to deliver person-centered recovery services. These services increase the likelihood of recovery, which reduces the high costs associated with emergency department visits, state mental health facilities, and criminal justice involvement.[25] House Bill 1486 (85R) directed HHSC to create a Medicaid benefit for peer services and assemble a stakeholder workgroup to provide input. The benefit should be in place by January 1, 2019. The state should continue the use of peer services to help address the shortage of licensed SUD treatment providers.

Provider capacity also continues to be a challenge. At many treatment facilities, the need frequently exceeds capacity. Charlie's Place Recovery Center testified that their waiting list averages 25-30 patients per day, which translates to a 6-9 week wait time to enter services for residential treatment. Beds are available to detox patients more quickly; however, if an inpatient/residential bed is not available immediately following detox, the individual often has to return to a living environment that is not conducive to their recovery.[26]

As of September 2018, There were 822 individuals on wait/interest lists for HHSC-delivered SUD treatment services through the indigent care program and Medicaid.[27]

Recovery supports

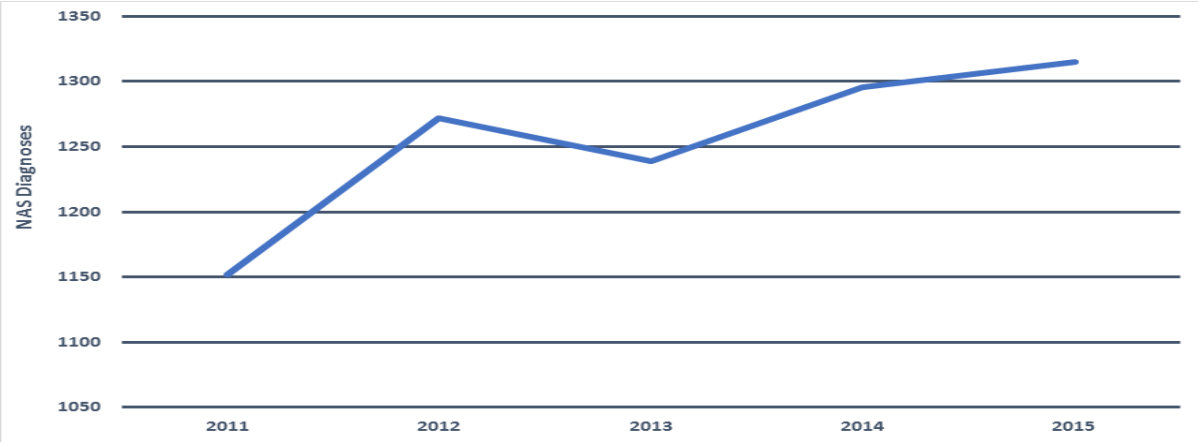
Individuals receiving SUD treatment through HHSC's indigent care programs can receive state-funded recovery supports via regional Recovery Support Services Organizations. These services encompass a wide array of non-clinical services and supports that help individuals sustain their recovery, such as recovery coaching, child care, life skills training, housing, employment support, and peer support. HHSC supports recovery housing through a $1.4 million contract with Oxford

House International (2018: $742,345 federal TTOR grant, $151,000 federal SABG grant, $520,000 general revenue). Oxford Houses are self-run, self-supported alcohol and drug-free homes for individuals in recovery. While some individuals may benefit from self-governing, unstaffed recovery housing, others may benefit from other levels of support. HHSC does not license recovery homes; however, optional certification is available through the National Alliance for Recovery Residences.[28] The Texas Behavioral Health Advisory Committee (BHAC) has recommended incentivizing this voluntary certification.[29]

Maternal Opioid Use and Neonatal Abstinence Syndrome

The incidence of neonatal abstinence syndrome (NAS), has tripled in the United States over the past decade. According to DSHS, "NAS can be diagnosed in newborns when the mother is physically dependent (and therefore the newborn is born dependent) on substance of abuse at the time of birth."[30] It primarily occurs when the mother is dependent on opioids. Bexar County has the highest incidence of NAS in Texas, accounting for 29 percent of NAS births.[31] In 2015, there were approximately 1,320 diagnoses statewide; however, the state only tracks NAS cases in deliveries funded by Medicaid.

Texas Neonatal Abstinence Syndrome Trends[32]



The average Medicaid neonatal intensive care unit cost for a newborn with NAS was $28,710 in 2015, and the average length of stay was 20.5 days.[33] The 84th Legislature granted DSHS an Exceptional Item request for $11.2 million in additional funds in the 2016-2017 biennium to support new and existing services aimed at reducing the incidence and severity of NAS. Such initiatives include outreach, coordinated opioid treatment services, the Pregnancy Stabilization Center in San Antonio, and Mommies Programs. *Mommies* is an integrated and collaborative model of care which reduces expensive newborn hospital stays and supports family preservation. HHSC estimates that for every dollar invested in NAS services, General Revenue savings equal nearly four dollars.[34]

Drug overdose and maternal mortality

Drug overdose was the leading cause of maternal deaths between 2012 and 2015, accounting for 64 percent of deaths. A vast majority took place more than 60 days postpartum, and nearly 60 percent involved an opioid. About 77 percent involved a combination of drugs.[35]

Specific Drugs Identified from Death Certificate Narratives for Drug Overdose Confirmed Maternal Deaths, 2012-2015[36]

Specific Drugs	Count
OPIOIDS	
Opioid	23
*Heroin**	18
*Fentanyl**	1
NON-OPIOIDS	
Sedative	22
Cocaine	12
Methamphetamine	9
Other	9
UNKNOWN	1

*Although considered opioids, heroin and fentanyl are each listed separately, because different tests are used to verify these two drugs.

DSHS partners with the Alliance for Innovation on Maternal Health (AIM) to reduce severe maternal morbidity using evidence-based systems to enhance maternal care. An AIM Maternal Safety Bundle is a collection of best-practices for improving maternal care, and Texas was invited to be a part of a multi-state collaborative to develop a bundle on "Obstetric Care for Women with Opioid Use Disorder." The bundle was piloted in September 2018 in hospitals that already had experience with quality improvement activities related to NAS. DSHS anticipates the bundle will be ready for statewide implementation in the Summer of 2019.[37] More information on the TexasAIM Initiative and maternal health is included in the committee's report on the monitoring of initiatives related to maternal mortality and morbidity.

Medication-Assisted Treatment

Medication-Assisted Treatment (MAT) combines effective medication and supportive counseling and therapies to treat Opioid Use Disorder (OUD) and prevent opioid overdose, relapse, and withdrawal. Currently in Texas, MAT is only provided to 14 percent of people being admitted for OUD to HHSC-funded indigent SUD services.[38]

Common medications used to treat OUD include methadone, buprenorphine, and naltrexone. These medications reduce withdrawal symptoms and psychological cravings, or decrease the efficacy of abused drugs. Methadone and buprenorphine are taken orally daily. Because these two drugs have the potential for abuse or diversion, many patients must travel daily to their provider to receive their dosage. Naltrexone is available as a daily oral tablet or an extended-release monthly injectable and can be prescribed or administered by anyone with prescribing authority. The drug prevents patients from experiencing a "high" from opioids or alcohol.

A number of barriers limit the expansion of MAT as an available option for all individuals seeking treatment for OUD:

- Methadone can only be dispensed for OUD treatment within licensed Opioid Treatment Programs (OTPs), which are closely licensed and regulated by SAMHSA, the DEA, and the state. Texas has 85 OTPs, but HHSC only contracts with a portion of them.
- Providers must have a DEA waiver and complete an eight hour training to prescribe buprenorphine outside of an OTP.
- Limited provider base
- Formulary and prior authorization restrictions
- Real and perceived liability concerns
- Stigma and misconceptions
- High cost of long-acting injectable naltrexone

Office-Based Opioid Treatment

The federal Drug Addiction Treatment Act (DATA) of 2000 expanded the clinical context of MAT to Office-Based Opioid Treatment (OBOT). Qualified physicians and practitioners are permitted to dispense and prescribe buprenorphine in settings other than OTPs. The Comprehensive Addiction and Recovery Act (CARA) of 2016 permits physician assistants and nurse practitioners to receive the DEA waiver and prescribe the drug. There are eight OBOT sites at LMHAs, and HHSC has posted an open enrollment opportunity to enroll more qualified prescribers and pharmacies to provide OBOT services.[39]

The Prescription Monitoring Program

The state's primary method for tracking prescriptions for highly addictive medications is the Prescription Monitoring Program (PMP), a statewide database collecting information from pharmacies on every controlled substance dispensed in the state. The database provides prescribers and dispensers with information on the patient's controlled substance prescription history that can help inform prescribing and dispensing decisions. In addition, regulatory agencies can use the database to investigate potential illicit behavior by licensees, such as overprescribing or improper dispensing.

In 2015, the Legislature transferred responsibility for the PMP from the Department of Public Safety to the Pharmacy Board, reflecting a desire to improve the system's usability and better utilize the information for public health purposes. The Pharmacy Board launched a new system which began operating on September 1, 2016. Citing a lack of use of the PMP by prescribers and dispensers, 85th Legislature passed House Bill 2561 (Thompson, S./Taylor, V.), which requires mandatory checking of the PMP prior to dispensing or prescribing.[40] This mandate will begin September 1, 2019.[41] The Joint Interim Committee on Prescribing and Dispensing Controlled Substances conducted an interim study monitoring the implementation of this mandate and the operation of the PMP. This report is due to the Legislature by January 1, 2019.

In FY18, 51.6 percent of licensed prescribers and dispensers were registered to use the PMP.[42] The program sends monthly alerts to prescribers and pharmacies when a patient is associated with five or more prescribers and five or more pharmacies, which could indicate "doctor-shopping" behavior. During 2017, a downward trend in these notifications suggests an overall decrease in doctor-shopping.[43]

While addressing overprescribing and doctor-shopping are important parts of tackling the substance abuse crisis, efforts should be made to connect identified doctor shoppers with SUD treatment services. There is evidence that individuals may seek opioids from illegal sources if they are no longer able to get their supply from pharmacies via prescriptions.[44]

Naloxone

Naloxone is a short acting opioid antagonist that can rapidly reverse overdose and prevent death. It is available as an injectable and a nasal spray. Senate Bill 1462 (84R) gave physicians the authority to prescribe naloxone, a lifesaving overdose reversal drug, not only to patients, but also to family members or friends of those who may be at risk of an overdose. The Texas Pharmacy Association (TPA) implemented an expansive physician-authorized Standing Order for Naloxone, allowing pharmacists to dispense the drug to patients or the family or friends of the patient without a prescription from a physician.

1115 Waiver

In December 2017, the centers for Medicaid and Medicaid Services (CMS) approved a five-year extension of the state's 1115 Healthcare Transformation Waiver through September 30, 2022. However, the Delivery System Reform Incentive Payment (DSRIP) Program will be phased out over the life of the new waiver. DSRIP payments are incentives paid to hospitals and other providers that develop programs or strategies to enhance access to care, increase the quality of care, the cost-effectiveness of care, and the health of patients and families served. Of the original projects, 56 included SUD services, such as integrated physical and behavioral health treatment, coordinated care among health systems, and improved interventions to justice-involved individuals with SUD.[45] HHSC must submit a DSRIP Transition Plan to CMS by October 1, 2019, which will describe how the state plans to assure sustainability of these efforts when DSRIP funding ends.[46]

Conclusion

While systems exist to support the needs of individuals with SUDs, the capacity and workforce are inadequate and there is no specific state plan to address the opioid crisis. While the 85th Legislature did pass legislation related to SUD prevention, more work is needed to bolster intervention, treatment, and recovery services. Further, legislation and regulation should be targeted at illicit use.

Recommendations

Improving Coordination and Data Collection

1. **Task the Behavioral Health Coordinating Council with the creation of a sub-plan for substance abuse.** This would promote consistency in substance use disorder related policy and guidelines across state systems. The Council has been successful in identifying gaps in mental health care, identifying resources to fill those gaps, and promoting cross-agency collaboration. The sub-plan should be created in conjunction with the Medical and Pharmacy Boards and should include:
    - Identification of a local entity responsible for acting as a single point of contact for the Substance Use Disorder sub-plan.
        - The challenges surrounding substance use disorder prevention, treatment, and intervention are not constant statewide.

- Evaluation of substance use disorder prevalence, service availability, capacity, and gaps both by region and statewide.
- Planning for the infusion of federal dollars
- Reviewing the current status of data collection needs by DSHS vital statistics
- Strategies for expanding capacity so more Texans in need can access treatment
- Work with institutes of higher education to support the Mental Health Loan Repayment Program for licensed chemical dependency counselors.
- Strategies for educating providers on appropriate referrals
- Strategies for increasing enrollment of MAT providers
- Supporting coordination between HHSC and DFPS regarding best practices when a baby is born substance-exposed
- Measuring providers' ability to recognize and provide integrated treatment for co-occurring substance use and mental health disorders
- Evaluating strategies for supporting recovery services

2. **HHSC and DSHS should improve data collection for and reporting on opioid deaths.** Additionally, HHSC should improve data reporting on co-occurring SUDs for all mental health clients served and evaluate capacity for treating co-occurring disorders.

3. **Expand access to Medication-Assisted Treatment.** In August 2018, the U.S. Food & Drug Administration issued guidance to encourage development of drugs to treat OUD.[47]

Pregnant and Postpartum Women

4. **Continue to support initiatives to reduce the incidence and severity of neonatal abstinence syndrome.**

5. **Increase targeted outreach and training for Healthy Texas Women and Family Planning Program providers regarding available SUD community resources and evidence-based screening/referral methods.**

Connecting Individuals to Treatment

6. **Examine opportunities to use telehealth to expand access to SUD treatment.**

7. **Develop methods to refer patients who are flagged by the Prescription Monitoring Program to SUD treatment services.**

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List,* March 22, 2018.
[2] Statewide Behavioral Health Coordinating Council "Texas Statewide Behavioral Health Strategic Plan, Fiscal Years 2017-2021." May 2016.
[3] *Supra* note 4.
[4] *Supra* note 2.
[5] Information provided by Meadows Mental Health Policy Institute.
[6] Texas Department of State Health Services *Maternal Mortality and Morbidity Task Force and Department of State Health Services joint biennial report,* July 2016.
[7] Department of State Health Services, "Texas Health Data: Opioid Related Deaths in Texas." http://healthdata.dshs.texas.gov/Opioids/Deaths.
[8] Information provided by Jane Maxwell, UT School of Social Work, April 13, 2018.

[9] Maxwell, J.C., *National Drug Early Warning System (NDEWS) State of Texas Sentinel Community Site (SCS) Drug Use Patterns and Trends, 2018.* University of Texas Steve Hicks School of Social Work, 2018.
[10] Centers for Disease Control and Prevention, National Center for Health Statistics.
[11] *Supra* note 4.
[12] *Supra* note 4.
[13] Information provided by the Health and Human Services Commission.
[14] Substance Abuse and Mental Health Services Administration "Co-Occurring Disorders." Retrieved at: https://www.samhsa.gov/disorders/co-occurring.
[15] Charlie's Place Recovery Center, *Testimony before the Senate Committee on Health and Human Services*. March 22, 2018.
[16] *Supra* note 4.
[17] Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services,* March 22, 2018.
[18] *Supra* note 16.
[19] *Supra* note 16.
[20] Health and Human Services Commission, *Evaluation of Medicaid Spending and Outcomes for Substance Use Disorder Treatment.* November 2017.
[21] *Supra* note 16.
[22] Vestal, C. *How severe is the shortage of substance abuse specialists?* Retried May 3, 2018 from http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/4/01/how-severe-is-the-shortage-of-substance-abuse-specialists. April 1, 2015.
[23] Department of State health Services. *The Mental Health Workforce Shortage in Texas.* September 2014.
[24] House Bill 3083, 85th Regular Session (Price/Hinojosa), 2017.
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Interim Charge 4A: Medicaid Quality

Interim Charge Language: *Review the Health and Human Services Commission's efforts to improve quality and efficiency in the Medicaid program, including pay-for-quality initiatives in Medicaid managed care. Compare alternative payment models and value-based payment arrangements with providers in Medicaid managed care, the Employees Retirement System, and the Teachers Retirement System, and identify areas for cross-collaboration and coordination among these entities.*

Hearing Information

The Senate Committee on Health and Human Services hearing was held on March 21, 2018. Individuals representing the Health and Human Services Commission (HHSC), the Employees Retirement System (ERS), the Teacher Retirement System (TRS), the Texas Association of Health Plans (TAHP), Superior Health Plan, the Texas Hospital Association (THA), and the Children's Hospital Association of Texas (CHAT) provided invited testimony.[1]

Note on agency reports: *Rider 61 directed HHSC to evaluate Medicaid managed care, including system performance and contract/oversight review. The Committee highly recommends that all interested parties review the Rider 61 report at: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/sb1-rider61-evaluation-medicaid-chip-august-2018.pdf*

Additionally, HHSC released their "Report on Pay-for-Quality Measures" in September 2018 as required by Rider 20, Senate Bill 1 85(R). The report details the medical and dental Pay-For-Quality programs. The Committee recommends interested parties review the agency's full report at:
https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/rider-20-pay-quality-measures-sept-2018.pdf.
HHSC also released a report on Quality-Based Payments in February of 2017. It can be found at:
https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/rider46-rider67-quality-based-payment-delivery-reforms-feb-2017.pdf

Background

Medicaid managed care has allowed the state to shift the Medicaid program from a volume-based fee-for-service (FFS) model to a modernized model of care focused on outcomes. The Legislature has directed HHSC to ensure providers and Managed Care Organizations (MCOs) are implementing quality programs so patients receive the best care possible in an appropriate setting. The Legislature has directed HHSC to develop, implement, and report on quality-based payment and delivery reforms in Medicaid and CHIP.

Sunset Review, HHSC Quality Plan, and Alternative Payment Models

The Sunset Commission's (Sunset) review of HHSC in 2014 found the agency did not have a strong plan in place to implement quality initiatives. As a result, Sunset made three quality related recommendations that were ultimately passed by the 84th Legislature in Senate Bill 200.

The first recommendation required HHSC to develop a comprehensive and coordinated operational plan designed to ensure consistent approaches in its major initiatives for improving the quality of health care.[2] HHSC released the *Health and Human Services Healthcare Quality Plan* in November 2017. The plan established six priorities to guide HHSC while implementing quality initiatives:

a. Keeping Texans healthy - through prevention and engagement to address root causes of poor health
b. Providing the right care in the right place - timely services in the least intensive/restrictive setting
c. Keeping patients free from harm - by building a safer healthcare system that limits human error
d. Promoting effective practices for chronic disease - to better manage this leading driver of healthcare costs
e. Supporting patients and families facing serious illness - to meet physical, emotional, and other needs
f. Attracting high performing professionals - for team-based, collaborative, and coordinated care[3]

The plan aims to improve the effectiveness of quality initiatives across HHS system agencies while emphasizing accountability of individuals, payers, providers, and health related public programs, targets value rather than cost containment alone, and builds on existing initiatives that support the transformation of healthcare from a volume-based system to a value-based system.[4]

Sunset's second and third recommendations required HHSC to develop a project to promote increased use of incentive-based payments by MCOs and to include a requirement for use of incentive-based payments in managed care Request for Proposals (RFPs). In response to these recommendations, HHSC updated the Uniform Managed Care Contract Manuel to require all Medicaid MCOs and Dental Management Organizations (DMOs) to achieve a minimum percentage of provider payments associated with an alternative payment model (APM) beginning January 2018. Figure 1 outlines this requirement.

HHSC's Requirements for MCOs use of APMs		
Period	Minimum Overall APM Ratio	Minimum Risk-Based APM Ratio
Year 1 (CY 2018)	>= 25%	>= 10%
Year 2 (CY 2019)	Year 1 Overall APM % + 25%	Year 1 Risk-Based APM %+25%
Year 3 (CY 2020)	Year 2 Overall APM % + 25%	Year 2 Risk-Based APM %+25%
Year 4 (CY 2021)	>= 50%	>= 25%

Figure 1. MCO APM Requirements.

HHSC adopted the APM definition published by the Health Care Payment Learning & Action Network (HCP-LAN) in their *APM Framework*; APMs are "payment approaches that incentivize high-quality and cost-efficient care (i.e. link portions of healthcare payment to measure(s) of value). They can apply to a specific clinical condition, a care episode, or a population. They could incorporate financial risk and rewards or simply be rewards-based."[5] The framework categorizes APMs by payment type, as seen in Figure 2. It is important to note that HHSC does not dictate the use of specific APMs. Instead, it is at the discretion of the MCO and provider to determine what type of APM would have the greatest impact on an individual's care

Figure 2. APM Framwork[6]

While the APM requirement is new, the idea of utilizing APMs is not. Prior to 2018, all MCOs and DMOs had some version of an APM in place. For example, United Healthcare entered into a capitated contract with a Texas-based Durable Medical Equipment (DME) company to pilot incentive-based provider payments with the goal of ensuring STAR+PLUS members were receiving and using the appropriate incontinence products. United identified 675 patients receiving supplies at an old address, experienced a 59.4 percent reduction in admissions for treatment of ulcers, and a 13.2 percent reduction in admissions due to falls. Members had the option to opt-out of the program and less than 1 percent did so.[7] Additionally, Driscoll Health Plan implemented programs requiring clinics to provide maternal vaccines in order to receive incentive payments. Incentive payments helped pay for the recruitment, placement, and retention of maternal fetal medicine specialists in underserved areas. Outcomes include a NICU cost per birth reduction of 40 percent between fiscal years 2009 and 2016 and an increase in maternal flu and whooping cough immunization rates.[8]

HHSC releases annual summaries of APMs submitted by MCOs. The summaries include contract type, level of risk for plan and provider, Medicaid program type, service area, provider type, performance measures, and more. Summaries from 2014, 2015, and 2016 can be found on HHSC's website: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/value-based-contracting.

Quality Programs at HHSC

HHSC operates a number of quality programs at the agency level in addition to the APM requirement. While the APM requirement focuses on the relationship between the MCO and the provider, these programs focus on the relationship between HHSC and MCO or provider directly. Quality programs at HHSC drive healthcare quality by rewarding effective models of care and by

holding MCOs accountable for not meeting certain quality metrics. A brief summary of the programs are listed below.

MCO Pay-for-Quality (P4Q) Program

MCO P4Q was created in 2014 for MCOs in the STAR, STAR+PLUS, and CHIP programs. STAR Kids will be added to the program beginning in calendar year 2020. The program places 3 percent of an MCO's capitation payment at risk, contingent upon performance on quality measures. Performance is measured in three ways:

1. Performance compared to benchmarks based on national standards
2. Performance compared to self year to year
3. Bonus measures, such as percentage of low-birthweight births

HHSC uses nationally recognized performance measures such as the Health Effectiveness Data Information Set (HEDIS) quality care measures and Potentially Preventable Events (PPEs) to track performance outcomes. More information about these measures can be found in the Data Metrics section of this report. If MCOs fail to meet their performance metrics, HHSC recoups up to 3 percent of their capitation. Any remaining funds after recoupments and distributions from measures 1 and 2 yield a bonus pool of funds for incentive payments to MCOs that meet certain bonus quality measures. HHSC has yet to recoup any funds in an effort to refine the program payment methodology and collect better program data. The revamped program began measuring quality as of January 1, 2018, and any necessary recoupments will be made in calendar year 2019. The 2018 P4Q quality measures focus on prevention, chronic disease management, and maternal and infant health.

DMO Pay-for-Quality (P4Q) Program

DMO P4Q was also created in 2014. The program places 1.5 percent of DMO capitation at risk, contingent upon their performance compared to performance from two years prior. Quality metrics focus on annual oral evaluations and cavity prevention. Similar to the MCO P4Q program, the DMO P4Q was redesigned to refine methodology, however, HHSC did fully implement the program and recoupments were made in 2014-2016.[9] Medicaid dental saw improvements in preventions and Texas Health Step measures, while CHIP dental saw improvements in all measures except for the rate of dental sealants.[10]

Dental P4Q Recoupments*	
2014	*$8,226,572.97*
2015	*$8,152,723.55*

*2016 recoupments are not finalized[11]

Hospital Quality-Based Payment Program

This program evaluates hospitals on quality measures such as potentially preventable readmissions (PPRs) and potentially preventable complications (PPCs). If a hospital does not meet specific performance metrics they are penalized.[12] Since its implementation, there has been a downturn in the statewide Medicaid PPR rate.

Fiscal Year	**Medicaid PPR Rate***
2012	*3.74%*
2013	*3.74%*
2014	*2.69%*
2015	*2.45%*

*PPR rates are calculated using a 15-day period between discharge and readmission[13]

PPR is also a quality metric under the MCO P4Q program, where positive results have been realized. For example, the STAR+PLUS program saw actual expenditures per 1,000 member months drop from $25,788 in 2013 to $17,732 in 2014 due to a reduction in hospital readmissions.[14]

Nursing Home Quality Incentive Payment Program (QIPP)
QIPP was established by HHSC Rider 97 in the 2016-2017 State Appropriations Act. As described on HHSC's website, "QIPP encourages nursing facilities to improve the quality and innovation of their services, using the CMS 5-star rating system as its measure of success for the following 4 quality measures: high-risk long-stay residents with pressure ulcers, percent of residents who received an antipsychotic medication (long-stay), residents experiencing one or more falls with major injury, and residents who were physically restrained."[15]

QIPP year one began on September 1, 2017 and 514 (430 Non-state government owned nursing facilities and 84 private nursing facilities) of the nearly 1,200 nursing homes in Texas participated (facilities must meet certain Medicaid bed day thresholds to participate). Participants are eligible to receive a share of $400 million for meeting quality metrics split between three components:

- **Component One**: Submission of a monthly Quality Assurance Performance Improvement Validation Report. This is only available to non-state governmental owned facilities.
- **Component Two**: Based on the four CMS 5-star quality measures above. Requires quarterly improvement compared to an established baseline.
- **Component Three**: Based on the same four quality measures as component two. Requires higher quarterly improvement than component two.

As of mid August 2018, $168.5 million was paid to facilities that met Component 1 and over $100 million was paid to facilities that met Components 2 and 3.[16] While this proves that individual facilities are improving quality compared to themselves, HHSC plans to compare performance of QIPP facilities to non-QIPP facilities to determine the success of the program once a full year of data is available. The Committee looks forward to reviewing that report.

Delivery System Reform Incentive Payment Program (DSRIP)
DSRIP, created in the state's original 5-year Medicaid 1115 Waiver, provides incentive payments to hospitals and other providers to transform service delivery practices in order to improve quality, health status, patient experience, coordination, and cost-effectiveness. Over the last five years, providers in Texas have received billions of dollars to create innovative care models locally. Project types include access to primary and specialty care, chronic care management, navigation of the healthcare system, and behavioral health care. This Committee's Interim Report to the 85th Legislature details the successes of DSRIP.

The new 5-year Medicaid 1115 Waiver, finalized in December 2017, extends DSRIP funding at current levels in the first two years of the Waiver but then gradually reduces funding to $0 over the life of Waiver.

DSRIP Funding, Waiver Demonstration Years (DY) 7-11	
DY 7 (Federal Fiscal Year ((FFY)) 18)	$3.1B*
DY 8 (FFY 19)	$3.1B*
DY 9 (FFY 20)	$2.91B
DY 10 (FFY 21)	$2.49B
DY 11 (FFY 22)	$0

*Funding in DYs 7 and 8 are maintained at previous Wavier funding levels

HHSC has been tasked with creating a DSRIP transition plan, due to CMS by October 1, 2019, to describe how the state will further develop health system reform when DSRIP funding is no longer available. This Committee will be closely monitoring the DSRIP transition.

Data Metrics

Data is a key component of operating quality programs. Without accurate data, benchmark measures and quality outcomes cannot be measured. HHSC uses a combination of established sets of national measures and state developed measures to track and monitor program and MCO performance. Additionally, HHSC uses a number of visual tools, dashboards, and online portals to make this information available to Medicaid members, providers, MCOs, the Legislature, and the public.

Quality Indicators

National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS)

A nationally recognized and validated set of measures used to gauge quality of care provided to members. Section 5 of the Rider 61(a) report details Texas HEDIS performance and trends by measure and Medicaid program, and compares the state's performance to other similar states and national benchmarks. The report found that "both the adult population and children population HEDIS measures saw modest improvement across the analysis period of 2014 through 2016."[17]

Agency for Healthcare Research and Pediatric Quality Indicators (PDIs)/Prevention Quality Indicators (PQIs)

PDIs use hospital discharge data to measure the quality of care provided to children. PQIs use hospital discharge data to measure quality of care for specific conditions known as ambulatory care sensitive conditions (ACSCs). ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.

Software Provided by 3M for Potentially Preventable Events (PPEs)

HHSC uses and collects data on Potentially Preventable Admissions, Potentially Preventable Readmissions, Potentially Preventable ER Visits, Potentially Preventable Complications, and Potentially Preventable Ancillary Services. The software used to compile and mine the data is provided by 3M at no cost to the state. This data is displayed for public use on the Texas Healthcare Learning Collaborative discussed later in this report.

Consumer Assessment of Healthcare Providers & Systems (CAHPS) Surveys
CAHPS are used to collect standardized information on members' experiences with health plans and services. CAHPS surveys are conducted biannually by the EQRO. Section 7 of the Rider 61(a) report details Texas CAHPS. The report found that "Texas experienced modest improvements in the member satisfaction scores for every program", however, "Texas performed lower than the national 50th percentile for four out of five composite measures."[18]

External Quality Review Organization (EQRO)
EQROs follow CMS protocols to assess access, utilization, and quality of care for members. Texas' EQRO, The Institute for Child Health Policy (ICHP) at the University of Florida, performs three CMS required functions related to Medicaid managed care quality:

1. Validates MCO Performance Improvement Projects (PIPs), federally required programs that use ongoing measurements and interventions to achieve improvement over time on health outcomes and enrollee satisfaction. MCOs must conduct two PIPs per program, and one must be in collaboration with another MCO, DMO, or DSRIP project.
2. Validates performance measures, including quality indicators.
3. Conducts a review to determine MCO compliance with federal requirements.

These functions allow for a comparison of findings across MCOs in each program used to develop goals and quality improvement activities for Medicaid and CHIP. ICHP conducts ongoing evaluations of MCO quality of care using MCO administrative data, including claims and encounter data, and reviews MCO documents and provider medical records, conducts interviews with MCO administrators, and conducts surveys of Medicaid and CHIP members, caregivers of members, and providers.

Federal regulations require MCOs to operate Quality Assessment and Performance Improvement (QAPI) Programs. These programs evaluate performance using objective quality standards, foster data-driven decision-making, and support programmatic improvements. MCOs report on their QAPI programs each year and these reports are evaluated by ICHP.

Stakeholder and Public Comparison Tools
Report Cards
Senate Bill 7 (82R) required HHSC to provide information on outcome and process measures to Medicaid and CHIP members regarding MCO performance during the enrollment process. To comply HHSC develops report cards for each managed care program in each service delivery area so members can compare MCOs on quality metrics such as experience with doctors and the MCO, preventative care, and controlling chronic diseases. Report cards are posted on HHSC's website, are updated annually, and are included in member Medicaid enrollment packets.

Texas Healthcare Learning Collaborative Portal (THLC)
The THLC, operated by ICHP, was created to strengthen public reporting and increase transparency and accountability of services and care provided under the Medicaid program.[19] ICHP compiles data submitted by MCOs and the state to allow the user to:

- View medical and dental quality of care visualizations by year, program, plan, and more
- View visualizations of PPEs by year, program, service area, and more
- View hospital PPCs and PPRs along with all payer PPE data

- Access additional information and other uploaded materials

Being able to compare metrics across program, service area, plan, etc. allows MCOs and providers to compare outcomes against themselves and others, and allows HHSC to view and track quality program outcomes. Ultimately, the goal of THLC is to "encourage further discussion on the aspects of care being tracked by these quality measures and spur collaboration among internal and external stakeholders to improve the quality of care and cost effectiveness of the Texas Medicaid system."[20] The portal can be found online at www.thlcportal.com.

Value-Based Payment and Quality Improvement Advisory Committee (Quality Committee)
The Quality Committee, housed at HHSC, studies and makes recommendations on:

- Value-based payment and quality improvement initiatives to promote better care, better outcomes and lower costs for publicly funded health care services
- Core metrics and a data analytics framework to support value-based purchasing and quality improvement in Medicaid/CHIP
- HHSC and managed care organization incentive and disincentive programs based on value
- The strategic direction for Medicaid/CHIP value-based programs[21]

Public hearings provide an opportunity for stakeholder input and collaboration to support improvement in value-based programs statewide. The Quality Committee is required to submit a written report to the Legislature by December 1 of even-numbered years. The Committee looks forward to reviewing the report and recommendations prior to the next legislative session.

Challenges to Success in Value-Based Care
The shift to value-based care requires changes on many fronts: how HHSC manages contracts, provider and MCO readiness and awareness of risk, embracing a system that focuses on outcomes instead of outputs, and the need for technological improvements to better display quality data in order to inform consumers and decision makers. HHSC's future role in managing Medicaid APMs is a fine balance between directing specific APMs and allowing MCO/provider innovation. Directing APMs would bring some level of consistency for providers and would allow the agency to implement a statewide approach to increase the quality of care for a specific service or population, while MCO/provider innovation allows those that are actually providing services the ability to create models of care they believe will have the greatest impact on quality. The current system promotes MCO and provider innovation which necessitates increased collaboration between the MCO and provider. This complicates matters due to varying levels of provider/MCO readiness and engagement. Flexibility in the new system allows MCOs and providers to create programs that incentivize and reward quality while considering readiness, risk, service area, and other demographics. As the system continues to shift, it is important that members, MCOs, providers, decision makers, and stakeholders have access to sufficient data to ensure APMs and other quality programs are achieving their intended effects: increasing the quality of care for Medicaid members while controlling costs.

Employees Retirement System (ERS) and Teacher Retirement System (TRS)

The Committee was also directed to review ERS and TRS quality programs, compare programs between ERS, TRS, and Medicaid Managed Care to identify opportunities for cross collaboration and coordination between agencies.

ERS

The majority of HealthSelect (ERS's health plan) spending is on value-based contracting arrangements. ERS highlighted a number of their successful quality programs during the hearing.

Patient-Centered Medical Homes (PCMHs)

PCMHs focus on the relationship between the member and their primary care physician, use evidence-based practices to inform patient and provider care decisions, and provide timely access to care via open scheduling and expanding provider hours. Since FY11-FY17, PCHMs have saved ERS $79.4 million, and providers have received $17.4 million in shared-savings in addition to their contracted reimbursement rates.[22]

Value-Based Incentive Design (VBID)

VBID's encourage patients to make healthier choices through cost sharing and by steering them toward cost-effective providers. Examples include reducing generic drug copays from $15 to $10, requiring the use of Centers of Excellence, offering diabetes prevention programs and diabetic supplies for free to members, and imposing a $300 copay per visit to out-of-network freestanding emergency rooms. In FY 17, ERS experienced a 15 percent higher utilization of, and 34 percent higher costs for, freestanding ER visits. This change has saved ERS $10 million in the first quarter of the calendar year.[23]

ERS also offers telemedicine/virtual visits at no cost to the member. Members can utilize virtual visits to avoid more expensive after-hour care. These visits also create a deterrent to out-of-network care. Virtual visits have saved the agency $1 million while increasing patient satisfaction.[24] Figure 3 shows typical plan cost by site for three common reasons for a virtual visit:[25]

Diagnosis	ER	PCP	Urgent Care	Virtual Visit
Upper Respiratory Infection	$1,015	$83	$67	$30
Viral Infection	$1,901	$78	$71	$29
Urinary Tract Infection	$1,097	$86	$68	$30

Figure 3. Virtual Visit Costs.

Real Appeal Program

ERS identified medical and pharmacy spending on diabetics as a major cost driver for HealthSelect. Twelve percent of HealthSelect members have diabetes but account for 34 percent of total HealthSelect cost.[26] To address this issue, ERS implemented a pre-diabetes intervention program called Real Appeal. The program is online and encourages weight loss through education about diet and exercise. Over 20,000 members enrolled, 90 percent of which were medically at risk, and have lost a total of 115,802 pounds since April 1, 2016. ERS projects $11 million in net savings over three years due to reduced diabetes claims.[27]

TRS

TRS operates four different reimbursement models with the aim of driving quality: pay-for-performance models (statewide), PCMHs, Accountable Care Organization (ACO) Attribution model (population health model of care), and an ACO Product (population health with shared savings and risk), accounting for nearly 40 percent of TRS participants in a value-based provider setting. TRS compares quality metrics across reimbursement models in order to identify opportunities to increase quality care within each model. For example, figure 4 indicates the need to increase colorectal cancer screenings within TRS' ACO product. TRS should share best practice value-based strategies across reimbursement models to ensure appropriate utilization.

Clinical Quality Measures	ACO Product	ACO Attributed	PCHM Rate	TRS Eligible
Colorectal Cancer Screening	33.5%	48.8%	44.8%	39.2%
Cervical Cancer Screening	63.3%	63.4%	68.2%	62.4%
Diabetes: Hemoglobin A1c Testing	83.8%	89.1%	89.7%	86.1%
Child Preventive Care Visits Age 2-19	46.4%	55.7%	56.0%	46.1%

Figure 4. TRS Quality Measures by care model.

Pharmacy

TRS highlighted a number of pharmacy value-based strategies that have resulted in estimated savings of $250 million while promoting adherence and managing fraud, waste, and abuse.[28] These include:

- Formulary Management – Driving patients to lower-cost drugs and covering the cost of certain drugs to promote adherence
- Utilization Management – Established quantity limits, implemented step-therapy and dose optimization
- Education Programs – Provides communications to members and providers on opportunities to save on alternatives, such as generics
- Fraud, Waste, and Abuse – Monitor claims to identify trends and outliers
- Opioid Management – Aligned with CDC guidelines to reduce misuse and abuse, prior authorization added when patient exceeds guidelines, not intended for patients with cancer or palliative care

Challenges to Cross-Collaboration among Medicaid, ERS, and TRS

Article IX, Section 10.06 of Senate Bill 1 (85R) required HHSC, ERS, TRS, and other health related agencies to develop recommendations and a comprehensive plan for an integrated health care information system that can compare data related to the healthcare system funded by appropriations made to these agencies. The plan notes differences between funding sources, the size and demographics of populations, and benefits offered make it challenging to compare data. Figure 5 outlines these differences.

	HHSC	ERS	TRS
FY 2017 Funding and Sources	$42,612 Million (State and Federal funds)	$3,385.5 Million (GR, GR-Dedicated funds; Employer surcharge of 1% payroll; Employees pay 50% of dependent contribution)	$3,484.1 Million (TRS-ActiveCare: State pays $75 month. School districts pay at least $150 months. Employees pay the remainder. TRS-Care: State contributes 1.25%, districts contribute 0.75%, and active employees contribute 0.65% of active employee payroll. Retirees contributed a fixed monthly premium)
Population Served	Primarily pregnant women and children with limited income and resources	State and higher education employees (except for UT and A&M University systems), retirees and their dependents	Employees and their dependents of participating public education entities; retirees and their dependents of participating entities (school districts, open enrollment charter schools, education service centers, etc.)
Number of Participants	4,039,590	534,053	760,744 (ActiveCare: 492,317; Care: 268,427)
Average Age	21 years	44 years	ActiveCare: 34 years Care: 68 years
Cost Sharing	Minimal	Yes	Yes

Figure 5. Cross Agency Comparisons.

*Additionally, each agency is governed by different laws and there are strict federal requirements in Medicaid that do not apply to ERS or TRS.[29]

While these differences make it difficult to truly compare effectiveness of quality programs across agencies, they do share similar cost drivers such as chronic disease care and drug prices. These agencies should share best practices to promote early intervention, ensure around the clock access to the appropriate level of in-network care, and incentivize the use of less costly prescription drugs.

Recommendations

1. **HHSC should hold MCOs financially accountable for not meeting quality metrics.**
   Now that HHSC has refined the P4Q program, timely recoupments should be made from MCOs that do not meet established quality metrics.

2. **HHSC should implement the incentive program that automatically enrolls Medicaid recipients who did not choose their managed care plan in a managed care plan based on quality as required by Senate Bill 7 (83R).**

3. **HHSC should consider options to enroll Medicaid recipients into managed care as soon as possible, if not immediately upon receiving coverage.**
   Currently, new Medicaid enrollees receive FFS benefits for nearly two months before they transition to managed care. This causes continuity of care issues. Enrolling individuals into managed care would improve outcomes and allows for better quality tracking over time.

4. **HHSC should better facilitate the ease of data reporting, comparing, and sharing.**
   As Medicaid becomes more outcome focused, HHSC should evaluate what MCOs and providers are required to submit to HHSC. Additionally, different pieces of quality data are published on five different websites. An effort to consolidate all quality information into a single location would be beneficial for MCOs, providers, and decision makers. Any consolidation efforts should consider the inclusion of a real-time, user friendly portal for data collection and presentation.

5. **The Legislature and HHSC should consider requiring MCOs to be accredited.**
   Of the 40 states that utilize managed care (including D.C.), 30 states require MCOs to obtain accreditation, and 26 of the 30 require National Committee for Quality Assurance (NCQA) accreditation. NCQA publishes streamlined HEDIS and CAHPS data annually, making it easy for providers, MCOs, clients, and decision makers to compare quality by program, by plan, and by state. Rider 61 utilized NCQA data to compare Texas' MCO performance to other states, however, only Texas MCOs that are NCQA accredited or voluntarily submitted data to NCQA are included in those benchmarks. Ensuring all Texas MCO HEDIS and CAHPS data is reported uniformly to a nationally recognized database will create a more meaningful comparison. Lastly, states can use this accreditation process in lieu of EQRO quality reviews,[30] allowing the EQRO to focus on other areas of interest such as network adequacy.

6. **Expand opportunities for ACOs in areas where possible, and increase participation in ACOs and PCMHs.**

7. **ERS and TRS should continue efforts to, and share practices that, encourage covered individuals to visit in-network, quality providers.**
   For example, TRS' presentation to Senate Finance on September 11, 2018 notes that inefficient utilization of emergency rooms is a major cost driver, with 16 percent of visits attributed to freestanding ERS. TRS should consider implementing cost sharing methods

similar to those established by ERS to deter patients from utilizing out-of-network freestanding ERs.

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List,* March 21, 2018.
[2] Sunset Advisory Commission Staff Report, *Health and Human Services Commission and System Issues,* July, 2015.
[3] Health and Human Services Commission, *Health and Human Services Healthcare Quality Plan*, November, 2017.
[4] Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services*, March 21, 2018.
[5] Health and Human Services Commission, *Webinar on Advancing Healthcare Value*, April 4, 2018.
[6] *Supra* note 6.
[7] Texas Association of Health Plans, *Testimony before the Senate Committee on Health and Human Services*, March 21, 2018.
[8] *Supra* note 8.
[9] information provided by Health and Human Services Commissions via email on August 15, 2018.
[10] *Supra* note 2.
[11] *Supra* note 2.
[12] Health and Human Services Commission, *Combined Report on Quality-Based Payment and Delivery Reforms in Medicaid and the Children's Health Insurance Program*, February 2017.
[13]*Supra* note 11.
[14] *Supra* note 7.
[15] Information provided on HHSC's website QIPP page.
[16] *Supra* note 10.
[17] Texas Health and Human Services Commission, *Rider 61: Evaluation of Medicaid and CHIP Managed Care Report*, August 17, 2018.
[18] *Supra* note 18.
[19] Texas Healthcare Learning Collaborative, *User Guide and Training Manual for Public Users.*
[20] Texas Healthcare Learning Collaborative, *Public Website Homepage*, thlcportal.com/home.
[21] Health and Human Services Commission, *Value-Based Payment and Quality Improvement Advisory Committee online homepage,* August 15, 2018.
[22] Employees Retirement System, *Testimony before the Senate Committee on Health and Human Services,* March 21, 2018.
[23] Employees Retirement System, *Testimony before the Senate Committee on Finance,* September 11, 2018.
[24] *Supra* note 22.
[25] *Supra* note 23.
[26] Health and Human Services Commission, *Analysis of Certain Healthcare Data*, May 1, 2018.
[27] *Supra* note 22.
[28] Teacher Retirement System, *Testimony before the Senate Committee on Health and Human Services,* March 21, 2018.
[29] *Supra* note 20.
[30] 42 CFR 438.360.

Interim Charge 4B: Medicaid Contract Compliance

Interim Charge Language: *Evaluate the Commission's efforts to ensure Medicaid managed care organizations' compliance with contractual obligations and the use of incentives and sanctions to enforce compliance. Assess the Commission's progress in implementing competitive bidding practices for Medicaid managed care contracts and other initiatives to ensure the best value for taxpayer dollars used in Medicaid managed care contracts.*

Hearing Information

The Senate Committee on Health and Human Services hearing was held on March 21, 2018. Individuals representing the Health and Human Services Commission (HHSC), the State Auditor's Office (SAO), the Texas Association of Health Plans (TAHP), the Texas Hospital Association (THA), and the Texas Medical Association (TMA) provided invited testimony.[1]

Introduction

With over 90 percent of Medicaid services in Texas provided via managed care, HHSC's role in Medicaid has transitioned from service provider to contract manager. HHSC contracts with MCOs to operate six managed care programs in the state. This entails over 50 contracts with 18 MCOs and two DMOs providing services in 13 service delivery areas (SDAs). To put this in perspective, Figure 1 shows which plans provide services across SDAs and Medicaid program type.[2]

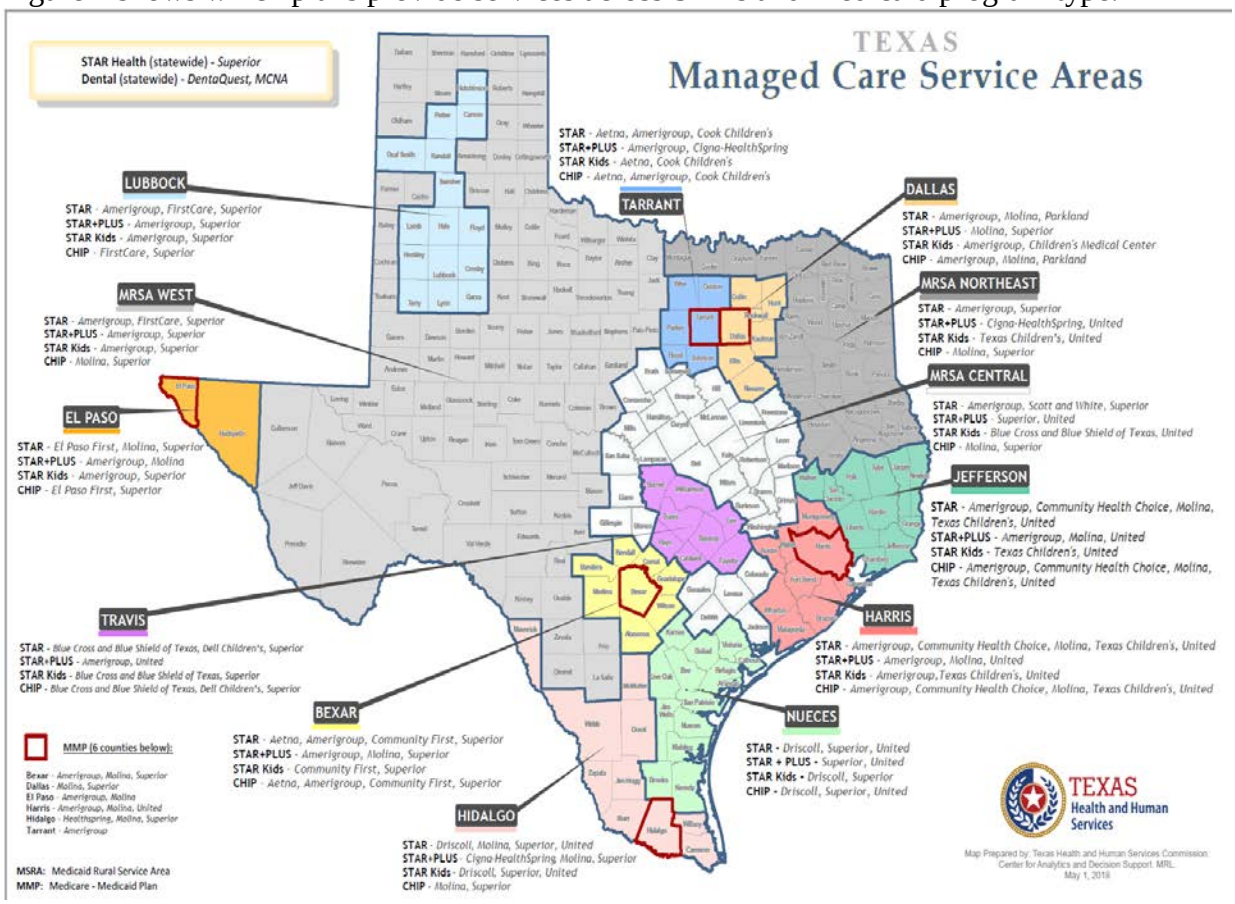


Figure 1. Managed Care SDAs.

It is vital that HHSC utilizes the necessary tools to hold MCOs accountable for meeting their contractual obligations to ensure that Medicaid and CHIP clients have access to and receive quality care through an efficiently managed system.

Note on procurement: *A number of troubling issues regarding HHSC's operation of Procurement and Contracting Services (PCS) were uncovered since the Committee's hearing. In response, three separate audits (an HHSC internal audit, an Office of the Inspector General audit, and an SAO audit) were performed to review all stages of the procurement process. Additionally, HHSC engaged a third party to assist the agency in addressing all issues identified by the audits. This report will not address the findings of these audits, but the Committee recommends HHSC continue to adopt best practices to address issues identified within the procurement process.*

Contract Monitoring

HHSC Medicaid managed care contract management can be divided into four subject areas; ongoing oversight, auditing, utilization reviews, and operational reviews. Monitoring outcomes can lead to the enforcement options discussed later in the report.

Ongoing Oversight – Quarterly Performance Reports (QPRs)

HHSC receives numerous deliverables quarterly to ensure providers and MCOs are meeting contract requirements. This includes oversight of operational and financial compliance. In the past HHSC relied on provider data, but they have recently begun collecting their own data from MCOs to ensure reliability.

Auditing

An annual financial audit is completed by two independent contractors, and supplemental audits or reviews can be done based on other identified issues. The annual financial audit timeline lasts between 18 and 20 months after the year ends, using the following process:

- In the first year, HHSC validates data from the Financial Statistical Report (FSR) on a quarterly basis
- After the first year, there is a 12 month waiting period for claims to run out
- At the end of the second year, a new audit begins
- Depending on audit results, HHSC assesses remedies for compliance issues from the prior year

A performance audit is completed for every MCO at least once every other year. A risk assessment is applied to determine which MCOs should receive a performance audit first. A number of other entities, such as CMS, SAO, and the OIG, perform audits regularly. These audits typically focus on specific topics.

Operational Reviews

HHSC recently began conducting biennial operational reviews which are completed by division to assess MCOs on critical indicators. Indicators include claims processing, provider relations, complaints/appeals, call center functioning, encounter data, utilization management, prior authorization processes, website critical elements, and additional enhancements and modules under development. These reviews are risk-driven, utilize medical staff, and can inform the focus of third-party audits.

Utilization Reviews
Senate Bill 348, passed by the 83rd Legislature, required HHSC to establish an annual utilization review (UR) process for MCOs participating in the STAR+PLUS Medicaid program. UR includes a thorough investigation, conducted by a nurse, of each MCO's procedures for determining whether a client should be enrolled in the STAR+PLUS Home and Community-Based Services (HCBS) program and if that client is receiving appropriate services.

HHSC uses a sampling method to determine the review population and to conduct a desk review of the assessment and service planning documentation. A home visit is conducted with the client and MCO service coordinator once the desk review is completed.

Due to the success of the UR process, HHSC submitted a request to transfer positions to expand UR to STAR Kids and STAR Health. The Legislature and the Governor's Office approved 47 additional UR staff to support reviews in STAR+PLUS, initiate reviews for STAR Kids Medically Dependent Children Program, and to support expansion of oversight of prior authorization for acute care services and long-term services and supports.[3]

In 2017, 358 Home and Community Based Services (HCBS) members from the five STAR+PLUS MCOs were selected for UR. As a result, $11.7 million in liquidated damages were issued to the MCOs and many have been placed on Corrective Action Plans.[4]

Contract Enforcement

Contract enforcement occurs in five stages to address non-compliance discovered through oversight and monitoring.

Stage 1 - Plans of Action
This is an informal improvement plan for first time minor violations. This allows HHSC and the MCOs to correct issues quickly and, if addressed, prevents more detrimental problems.

Stage 2 - Corrective Action Plans (CAPs)
HHSC administers CAPs monthly to MCOs who do not meet 75 percent compliance with contracting standards and procedures. This threshold will jump to 90 percent in January 2019. [5] If an MCO is found to be out of compliance, they must provide HHSC with an explanation of why they are out of compliance, an assessment of the cause, any actions taken to cure or resolve the deficiencies, and actions taken to prevent future occurrences. Figure 2 shows the number of CAPs issued since 2016.[6]

State Fiscal Year	CAPs Issued
2016	*47*
2017	*67*
2018	*96*

Figure 2. CAPs issued to MCOs.

Stage 3 - Liquidated Damages (LDs)
LDs are assessed quarterly to address any harm incurred by the state due to MCO contractual non-compliance.[7] HHSC recently formalized their process for assessing liquidated damages. As a result, the agency has seen an increase of over 400 percent in LDs for the first three quarters of 2017 compared to 2016.[8]

Year LDs Assessed	Amount
2014	*$2.1 million*
2015	*$2.4 million*
2016	*$5.2 million*
Q1-Q3 2017	*$27 million*

Stage 4 - Suspension of Default Enrollment
Currently, when a Medicaid client doesn't select an MCO they are automatically enrolled into one of the plans in their SDA. In stage 4, automatic enrollment is suspended making it difficult for MCOs to gain efficiencies in the economy of scale. This has happened once, in 2012.

Stage 5 - Contract Termination
An MCO contract can be terminated by HHSC, an MCO, or by a mutual agreement. Contract termination involves a formal process to end the contract along with an entire process for moving members and their health information (i.e. prior authorizations, claims history, case notes) to receiving plans. HHSC has never terminated a contract for an MCO failing to abide by contract standards, however, contract terminations have happened when an MCO leaves the Medicaid market for various reasons.

Overall Impacts
CAPs and LDs are publically posted on HHSC's website. This can affect an MCO's ability to do business in another state. The increase in CAPs and LDs can be attributed to the maturing of HHSC's contract enforcement mechanisms. HHSC should continue to adapt oversight practices that are reflective of the managed care environment.

Financial Safeguards
The state created a number of safeguards to ensure fiscal responsibility within the managed care program. Major components include caps on administrative expenses and rebates on excess profit. Additionally, the Legislature reduced the risk margins for most programs by 0.5 percent (a 25 percent total reduction) which limited MCO profits resulting in savings to the state.

MCOs have caps on administrative expenses and anything above that cap is considered profit. The cap is increased on a per member per month (PMPM) basis depending on the contract and patient population. Additionally, HHSC collects excess profits from MCOs on a sliding scale if profits are greater than three percent. This is known as the experience rebate.

Experience Rebate	
If profit is	HHSC recovers
< 3%	0
3% < 5%	20%
5% < 7%	40%
7% < 9%	60%
9% < 12%	80%
12% or greater	100%

Figure 3 includes an analysis of total MCO profitability and the experience rebates for fiscal years 2016 and 2017.[9]

Total MCO Profitability and Experience Rebate for Fiscal Years 2016 and 2017	
Gross Revenue	42,421,821
Net Income before Experience Rebate	1,286,694
%	3.0%
Experience Rebate	141,721
Net Income after Experience Rebate	1,144,972
%	2.7%

Figure 3. Analysis of MCO Profitability and Experience Rebates in $000.

Network Adequacy Oversight

Senate Bill 760 passed by the 84th Legislature required HHSC to modernize access standards on MCO provider networks. Major provisions of the legislation included time and distance standards, provider directory improvements, out-of-area provider listings, expediting credentialing, and the monitoring of appointment wait times. As a result, HHSC implemented time and distance standards that are more stringent than what is required by CMS. A detailed outline of these requirements can be found on HHSC's website and on page 111 of the Rider 61(a) report. Sixteen out of the 20 MCOs are currently on or have been on CAPs related to network adequacy.[10] HHSC is implementing a graduated remedy and MCOs will be subject to higher standards and liquidated damages in 2019.[11]

The state's EQRO conducted secret shopper studies from 2015-2016 to evaluate appointment wait time standards. As a result, HHSC has imposed CAPs on all MCOs in at least one SDA for not meeting appointment availability standards.[12] Most troubling was the percentage of prenatal care providers not meeting the standard in 2016:[13]

Level/Type of Care	Time to Treatment	% of Providers Meeting the Standard in 2016
Prenatal Care (high risk)	Within five calendar days	44%
Prenatal Care (new member in 3rd trimester)	Within five calendar days	38%

*MCO performance on wait time standards in STAR, CHIP, and STAR+PLUS

In response, HHSC has increased prenatal care quality metrics for MCOs in the P4Q program and has formed a cross-divisional workgroup to take a broad-based approach to ensure network

adequacy.[14] Efforts include the creation of a MCO specific network adequacy dashboard that will be available to the public. The Committee looks forward to reviewing the outcomes of the new prenatal P4Q measures as well as the results of the workgroup.

Competitive Bidding

In early 2018, HHSC released a Request for Proposal (RFP) to competitively bid for administration services in STAR, CHIP, and dental services. After feedback from the stakeholders, in combination with procurement woes, the agency decided to pull competitive bidding from the RFP. HHSC has since released an RFI to obtain feedback from other states, MCOs, and providers regarding competitive bidding in managed care. They plan to release a report by the end of 2018. The Committee looks forward to reviewing the report. Currently, competitive bidding on administration is only a component in the Medicaid Transportation Program contracts.

Recommendations

1. **HHSC should continue to utilize and expand contract enforcement mechanisms that reflect the managed care environment in order to better hold MCOs accountable.**

2. **HHSC should ensure MCOs maintain adequate networks so Medicaid enrollees have access to all appropriate services, including maternal and behavioral health care.** If MCOs fail to maintain adequate networks, HHSC should hold the plans financially accountable. This should also apply to the quality of MCO provider directories.

3. **HHSC should reconfigure and reduce the number of managed care service delivery areas.** The current configuration of SDAs is overly burdensome. Reducing the number of SDAs could reduce the number of contracts, allowing HHSC to focus their oversight efforts. HHSC plans to release an RFI later this year regarding SDA configuration.

4. **HHSC should implement competitive bidding practices into managed care procurements.** CMS requires managed care rates to be actuarially sound, making it difficult to competitively bid full contracts amounts. However, the agency could competitively bid on administration costs or the experience rebate, while keeping unintended consequences in mind. For example, safeguards would need to be established to prevent an MCO that is unlikely to be profitable from underbidding on the experience rebate. If it is determined that competitive bidding would not be beneficial, the agency should consider lowering the profit thresholds of the experience rebate, including lowering the current 12 percent or greater profit cap, or increasing the amounts HHSC recovers.

5. **HHSC and MCOs should streamline their complaints and appeals processes.** A recent report found that HHSC's processes for logging complaints are not structured or standardized.[15] Complaints can be reported to MCOs, the Ombudsman's Office, and other areas of HHSC making it difficult to log and track complaints, often causing duplication

and redundancy. TDI has a robust method for tracking and resolving complaints. HHSC and TDI should share complaint process best practices.

6. **HHSC and MCOs should institute a clear and accountable Fair Hearings process, including the use of Independent Review Organizations (IRO) for cases of medical necessity.** TDI has a robust IRO process that includes specific response times based on severity of case and requires all appealed denials to be reviewed by the same type of practitioner as the treating practitioner.[16] HHSC should implement a similar IRO process to ensure MCO denials fall within their contractual obligation to cover medically necessary services in the same amount, duration, and scope as is available through FFS Medicaid. The Legislature should also ensure HHSC has the ability to enforce IRO decisions.

[1] Senate Committee on Health and Human Services Commission, *Interim Hearing Witness List*, March 21, 2018.
[2] Map provided by the Texas Health and Humans Services Commission website, accessed September 25, 2018, https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/managed-care-service-areas-map.pdf.
[3] Information provided by the Texas Health and Human Services Commission, *Utilization Reviews for Long-term Services and Supports.*
[4] *Supra* note 3.
[5] Information provided by the Texas Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services*, March 21, 2018.
[6] Texas Health and Human Services Commission, *Rider Report 61: Final Comprehensive Report*, August 17, 2018.
[7] Information provided by the Texas Health and Human Services Commission, *Remedies for Contractual Non-Compliance.*
[8] *Supra* note 7.
[9] Information provided by the Texas Health and Human Services Commission via email on September 28, 2018.
[10] Information provided by the Texas Health and Human Services Commission, *HHSC Oversight of Member Access to Network Providers.*
[11] *Supra* note 7.
[12] *Supra* note 7.
[13] *Supra* note 7.
[14] *Supra* note 7.
[15] *Supra* note *6* .
[16] Title 28, Part 1, Chapter 12, Texas Administrative Code.

Interim Charge 5: Health Care Cost Transparency

Interim Charge Language: *Study efforts by the Department of State Health Services and the Texas Department of Insurance to increase health care cost transparency, including a review of the Texas Health Care Information Collection (THCIC) system, and the Consumer Guide to Healthcare. Recommend ways to make provider and facility fees more accessible to consumers to improve health care cost transparency, increase quality of care, and create a more informed health care consumer base.*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on March 21, 2018. Invited testimony was provided by individuals representing the Department of State Health Services (DSHS), the Texas Department of Insurance (TDI), the Office of Public Insurance Council (OPIC), the Texas Medical Association (TMA), the Texas Hospital Association (THA), and the Texas Ambulatory Surgery Center Society.

Introduction

As health care prices increase, consumers are asked to bear a larger share of the costs. While utilization of most health care services remained the same or declined between 2012 and 2016, per person spending has grown annually, both for insurers and consumers.[1] Emergency care prices alone have risen by more than 31 percent.[2] Further, health care expenditures account for nearly half of the state's budget.[3] Demand for transparency resources is growing, and while Texas agencies and associations operate several consumer resources for understanding health care costs, the information is often disjointed and disconnected. A number of agencies are tasked with collection and dissemination of health care cost and quality data, but there is limited coordination between agencies. Many of the resources available are not practically useful to the average consumer. Further, making costs transparent requires collaboration between providers, facilities, insurers, and consumers. The chart below provides a snapshot of some of the resources discussed in this report.

Consumer Resources for Cost and Quality Transparency

<table>
<tr><th>Department of State Health Services</th><th>Department of Insurance</th><th>Office of Public Insurance Council</th><th>Texas Hospital Association</th><th>Health Insurance Carriers</th></tr>
<tr><td>TX Health Care Information Collection</td><td>Consumer Reimbursement Rate Guide</td><td>Guide to HMO Quality</td><td rowspan="3">PricePoint</td><td rowspan="3">Online shopping tools</td></tr>
<tr><td>Texas Health Data</td><td>Health Plan Compare</td><td rowspan="2">Comparing Texas HMOs</td></tr>
<tr><td>Consumer Guide to Healthcare</td><td>Texas Health Options</td></tr>
</table>

The Texas Health Care Information Collection System (THCIC)

THCIC was established in 1995 and exists within DSHS' Center for Health Statistics. Statute directs THCIC to collect data and report on activity in health care facilities and health benefit plans operating in Texas, with the goal of providing data that enables consumers to have information on

the cost and quality of health care services.[4] However, interested parties have raised doubts about the data's usefulness. The Sunset Commission found in its 2015 review of THCIC that DSHS "has not met expectations to provide useful consumer data to guide informed health care choices."[5] The information available is not user-friendly or, generally, timely. The Commission directed the agency to continue to focus on improving the usefulness and understandability of THCIC data for the general public.[6]

It is important to note that the THCIC system only captures health care charges, not the amounts paid or actual costs to the consumer or insurer. Other challenges include the fact that charges from physicians or physician groups are not captured, and that the outpatient data set is incomplete.[7]

In Fiscal Year 2017, the legislature appropriated $1.8 million for THCIC, which was used for a third party contract, as well as staffing needs. The department collected $586,000 from data fees.[8]

How THCIC collects data

DSHS currently collects data from hospitals (including emergency departments) and ambulatory surgical centers (ASCs), but is also authorized to collect from chemical dependency treatment facilities, rental dialysis facilities, birthing centers, rural health clinics, federally qualified health centers, and free-standing imaging centers. Freestanding Emergency Rooms (FSERs) are not included due to the age of the statute.[9] The agency contracts with a vendor to collect both inpatient and outpatient discharge data from hospitals and ASCs. The data collected is based on claims information that health care providers use for billing purposes, submitted in a standard format established by the American National Standards Institute. THCIC data collection is split into two sets of data sources: discharge data (all payor claims via the Health Care Data Collection System (HCDCS)) and commercial insurance organization data via the Healthcare Effectiveness Data and Information Set (HEDIS).

- *Discharge Data--Health Care Data Collection System (HCDCS):* Approximately 29 million inpatient, outpatient, and emergency department (ED) records are collected annually. Statute requires quarterly data submission and requires a review period of 45 days for submitters to make any corrections. An additional review period (60 days) is required whenever submitted data will be included in a report released to the public. System 13, Inc. has been the contractor for data collection, processing, housing, and online correction and certification for data submitters since 1998.[10]

What THCIC Collects: Discharge Data[11]

Data Collected (examples)
Health care **Charges:** what is initially billed, before adjustments
Length of stay
Patient demographics
Major procedures information
Quality of care indicators
Diagnoses

Data NOT Collected
Actual health care **costs to provide billed services**
What is finally billed, what is actually **paid,** after adjustments
Data from electronic medical records
Physician charges

- *Insurance Data--Healthcare Effectiveness Data and Information Set (HEDIS):* HEDIS is the national data set that measures performance on key aspects of care and service by health plans. Examples of HEDIS measures include: screening for certain conditions, including breast and cervical cancer; medication management for patients with asthma; and emergency department utilization.[12] Health Maintenance Organizations (HMOs) are required to report HEDIS measures to DSHS on an annual basis, at an estimated cost to HMOs of approximately $90,000 annually. DSHS does not currently collect information from Medicaid Managed Care Organizations (MCOs), though the Health and Human Services Commission (HHSC) does collect MCO HEDIS measures.[13] HEDIS collection allows for both consumer comparison, as well as tracking of year-to-year performance. The HEDIS reports are provided to the Office of Public Insurance Council (OPIC), who then releases a guide for consumers. The guide may assist individuals in selecting a type of plan or specific plan, based on its performance measures. The guide also provides an analysis of care effectiveness, availability, and utilization of certain services and treatments. However, the guide is limited in its usefulness because it excludes Exclusive Provider Organizations (EPOs) and Preferred Provider Organizations (PPOs).[14] There is also confusion surrounding which health benefit plans should be reporting this data, stemming from differences in the way Affordable Care Act marketplace enrollees and commercial enrollees are counted.[15]

Availability of THCIC data

THCIC data is made available to the public via published reports, the Texas Health Data website, quality indicator reports, research data files, and public use data files, as well as legislative reports.

- *Public Use Data Files (PUDF)*: This is the most comprehensive product available to the public. The PUDF includes inpatient, limited outpatient, and ED datasets (not including freestanding ER facilities). Recent years of the PUDF are available for a fee, while older files are available online at no cost. There were 203 requests for these datasets in 2017.
- *Research Data Files (RDF):* RDFs are specially prepared files for approved research purposes. These are developed/prepared only after a request receives Institutional Review Board (IRB) approval. A fee may be charged, depending on the nature of the request. There were 34 requests for these files in 2017.
- *Quality Indicator Reports:* This includes three types of reports: inpatient/prevention, pediatric, and patient safety. Each uses a different set of metrics to analyze quality, and the reports include a series of standardized measures that allow for a comparative assessment of hospitals.[16]

Texas Health Data

The creation and expansion of the DSHS Texas Health Data website was an important step in making health care data more useful and transparent to consumers, but it is only a first step. Texas Health Data is a user-friendly interactive website housed at the Center for Health Statistics that allows users to query DSHS public health datasets for statistical reports. It also includes some inpatient data and quality indicators. Significant strides are underway in expanding access to the datasets available at DSHS, including THCIC data.[17] The agency is:

- Continuing to increase the number of datasets and the array of search tools available;

- Polling partners to assess needs for data;
- Balancing access between fully aggregated data results and full access to raw data for data partners to conduct their own analyses; and
- Developing an assessment to improve the website by focusing on timeliness, relevancy, and accuracy.[18]

The Consumer Guide to Healthcare

Chapter 324, Health and Safety Code, and Chapter 154, Occupations Code require DSHS and the Texas Medical Board (TMB) to create a guide for consumers offering information on the quality of health care and health care billing and pricing practices. The guide is housed on the DSHS website and includes definitions, indicators of inpatient care in Texas hospitals, and guides to health care charges/billing. It also includes links to websites such as the Texas Hospital Association's (THA) PricePoint, which allows consumers to receive basic, hospital-specific information about services and charges, and a number of guides developed by TDI on health care billing.[19] While the guide meets statutory requirements, it is not easily accessible or practically useful to consumers, defeating its purpose. The external links provide more plain language and accessibility than the DSHS guide.

Texas Department of Insurance (TDI)

TDI operates Texas Health Options, a plain-language website that helps consumers understand how to find and use health insurance, along with two statutorily-required data collection efforts, known collectively as the Health Transparency Initiatives. These data collection initiatives, discussed below, were put into place by Senate Bill 1731 (80R), in 2007.[20]

Consumer Reimbursement Rate Guide

TDI is required to collect information from health benefit plan carriers about the price of medical services and publish a summary of this information online.[21] Health benefit plan carriers submit reimbursement rates (amounts billed and amounts allowed) to TDI for certain health care services, and the agency uses this data to produce the Consumer Reimbursement Rate Guide, an online tool that allows Texans to search for the average price for medical procedures based on geographic regions, and provides information on the typical price for common services in the private market.[22] It is important to note that TDI only has the authority to regulate 17 percent of the state's health insurance market, so this guide only reflects costs for a portion of consumers.[23]

In May 2018, TDI launched an updated version of the Consumer Reimbursement Rate Guide, developed in partnership with the University of Texas School of Public Health (UTSPH). The previous data was limited to separate and individual medical billing codes and could be misleading, as it did not reflect a consumer's actual costs for services. According to TDI, "a single billing code rarely represents the full scope of items a consumer will be billed for after seeking care."[24] TDI and UTSPH developed a new collection methodology that gives consumers cost estimates for full "episodes of care" around 30 common services. Starting with 2016 data, health plans are required to submit reimbursement rates for episodes of care rather than for Current Procedural Terminology (CPT) codes.[25] While the new website more accurately reflects costs of care, it is still only minimally useful to insured consumers. The website displays the "total billed" amount a provider bills to a health plan, and the "total allowed" amount, which is the maximum amount a plan will

pay for a covered service. This information does not give a clear picture of what an insured individual might expect to pay out of their own pocket.

Health Plan Compare
TDI is currently evaluating an approach to develop a website displaying data that health plans must report each year, such as enrollee satisfaction, quality of care, coverage areas, premium costs, plan costs, premium increases, benefits provided, copayments, and deductibles. This initiative was required by Senate Bill 1731 (80R), but was temporarily put on hold to avoid duplication with federal reporting requirements resulting from the Affordable Care Act. With the recent changes to the Affordable Care Act, TDI has resumed work on Health Plan Compare and anticipates the website design will be complete in late 2018, and populated with actual carrier data in 2019.[26]

The Office of Public Insurance Counsel (OPIC)

OPIC represents the interests of consumers as a class in insurance matters. The Legislature created OPIC in 1991 as an independent agency to advocate for consumers in rate, form, and rule proceedings, primarily at TDI.[27]

The agency's health care transparency roles include: "(i) preparing two reports on Health Maintenance Organizations (HMOs) and (ii) providing consumer education on health insurance issues."[28] Texas Insurance Code, Chapter 501, Section 253 allows OPIC access to THCIC data as long as it furthers OPIC duties and is used for public benefit.[29] The agency uses HEDIS data from DSHS to publish the Texas Guide to HMO Quality and Comparing Texas HMOs, which consumers can use as resources when selecting a type of plan or specific plan.[30] As discussed above, these reports do not include information about PPOs or EPOs.

Transparency Tools in Place for Insurers and Providers

Health insurance carriers, out-of-network physicians, and facilities must provide cost estimates to enrollees and patients for elective and non-emergency procedures upon request, generally within 10 days.[31] Facilities and physicians are also responsible for disclosures regarding billing policies and network status, and itemized statements of charges, if requested.[32]

State law requires health insurance carriers to use information technology to provide information about costs, such as information on the "estimated financial responsibility for the health care provided to the enrollee."[33] Many insurers have developed online tools that allow consumers to shop for providers and receive estimates on their costs of care; however, few consumers use these tools.[34] While Texans receiving elective care may have the opportunity to use available tools to request cost estimates, those receiving care in emergency departments often cannot, due to the nature of emergency care.

Surprise Billing
Insured Texans receiving care in hospital or emergency department settings are at risk for balance billing, often known as surprise billing. Balance billing is the practice of billing a patient directly for the costs of care that were not covered by the insurance carrier. These bills are often shocking to patients. This can occur when the patient is unknowingly treated by an out-of-network provider while at an in-network hospital. While health insurers and facilities are required to provide notice that consumers may be balance billed, the opportunity for disclosure may not be possible before

emergency care must be provided, or the consumer may not adequately understand the risk of balance billing.

To combat surprise bills, Senate Bill 507 (85R) expanded the availability of mediation for out-of-network claims. Patients who receive a balance bill exceeding $500 are eligible for mediation through TDI.[35] However, patients must meet their deductible first, and those without TDI-regulated insurance (nearly two-thirds) are ineligible. More consumer protections and education are needed. Further, having an adequate network and accurate provider directories can minimize the risk of a patient unknowingly or unavoidably receiving care from an out-of-network provider.

FSERs have been receiving attention in recent years for sending patients hefty bills after treating minor conditions. These bills can include exorbitant facility fees. FSERs are required to post the names of the insurance companies they are in network with, or post that they are not in network with any companies, but many consumers are still confused about whether these facilities are in-network with their insurance. In some cases, a facility may tell a patient they "accept" their insurance, or may even use an insurance company's logo on their website, but this does not necessarily mean they are in-network.[36] According to the Texas Association of Health Plans, "Freestanding ERs are responsible for nearly 70 percent of out-of-network ER facility claims in Texas."[37]

Network Adequacy

Having an adequate network and updated provider directories can limit out-of-network balance billing. TDI currently collects network adequacy information for regulatory purposes, but these requirements were not established for the purpose of providing that information to the public. Health insurance carriers are only required to update their directories once per month, and annual network adequacy reports provide limited information.[38] TDI has in the past been pushed to provide more information to the public about what the networks look like. Legislation filed during the 85th legislative session would have given OPIC the authority to monitor the network adequacy of HMO, PPO, and EPO networks and lodge complains with TDI on the overall adequacy of a plan's network.[39]

Recommendations

Improve Coordination

1. **Direct DSHS, OPIC, and TDI to leverage information and efforts. The agencies should jointly:**

- Assess the scope of information provided to consumers.
- Improve consumer access to education, consumer tools, and healthcare cost data.
- Evaluate centralizing the state's transparency resources.
- Evaluate strategies to improve health insurance literacy across the spectrum of consumers.

Expanding the Usefulness of THCIC Data

2. **Direct DSHS to pursue efforts to enhance the interpretation, display, and usefulness of THCIC data for consumers.**

3. **Collect the complete dataset from facilities DSHS is authorized to collect from to further enhance analysis of healthcare quality and charges.** This should include revising statute to allow DSHS to collect data from Freestanding Emergency Rooms.

4. **Direct DSHS to continue enhancing Texas Health Data utilization to improve data access to the public.**

5. **Direct DSHS to streamline data review processes for developing legislative and other reports.**

Facilities and Providers

6. **Study facility and patient observation fees to determine which providers should be able to charge them.** This study should also include ways to make these fees more transparent to consumers.

7. **Prohibit the use of misleading language or advertisement regarding a facility being in-network with insurance carriers.**

8. **Give the attorney general authority to bring action against providers who charge consumers "unconscionable" rates.** Legislation filed during the 85th Legislative Session would have given the attorney general the ability to pursue action only when the price is 150 percent or more of the average hospital charge for a similar service.[40]

Expand OPIC Activities

9. **Grant OPIC the ability to file a complaint with TDI upon discovery of an inadequate network, or other network adequacy violations, including the accuracy of provider directories.** OPIC should also have the authority to intervene in access plan filings and network waiver filings by health insurers.

10. **Require EPOs and PPOs to report HEDIS measures to DSHS, and require OPIC to produce annual EPO and PPO report cards along with HMO report cards.**

11. **Add network adequacy as a component of OPIC report cards.**

Health Plan Activities

12. **Require health plans to update their provider directories more frequently.**

[1] Health Care Cost Institute, *2016 Health Care Cost and Utilization Report.*
[2] *Supra* note 1.
[3] Texas Comptroller of Public Accounts, *Texas Health Care Spending Report: Fiscal Year 2015*, 2017.
[4] Health and Safety Code, Chapter 108.
[5] Texas Sunset Commission, *Department of State Health Services Staff Report with Final Results, Issue 7*, 2015.
[6] *Supra* note 5.
[7] Information provided by DSHS via email.
[8] Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services.* March 21, 2018.
[9] *Supra* note 7.

[10] Department of State Health Services, *Texas Health Care Information Collection (THCIC)*, 2017.
[11] *Supra* note 8.
[12] *Supra* note 7.
[13] *Supra* note 7.
[14] *Supra* note 10.
[15] *Supra* note 7.
[16] *Supra* note 7.
[17] *Supra* note 7.
[18] *Supra* note 7.
[19] Department of State Health Services, "Consumer Guide to Healthcare" retrieved from: https://www.dshs.texas.gov/thcic/consumerguide/ConsumerGuide.shtm.
[20] Senate Bill 1731, 80th Regular Session (Duncan/Isett, Carl), 2007.
[21] *Supra* note 20.
[22] *Supra* note 8.
[23] Letter to the Chair of the Health and Human Services Committee from Libby Camp, TDI Associate Commissioner for Agency Affairs and Director of Government Relations.
[24] *Supra* note 23.
[25] *Supra* note 23.
[26] Texas Department of Insurance, *Testimony before the Senate Committee on Health and Human Services.* March 21, 2018.
[27] Office of Public Insurance Counsel, *Testimony before the Senate Committee on Health and Human Services.* March 21, 2018.
[28] *Supra* note 28.
[29] Texas Insurance Code Section 501.253.
[30] *Supra* note 27.
[31] *Supra* note 20.
[32] Texas Medical Association, *Testimony before the Senate Committee on Health and Human Services.* March 21, 2018.
[33] Texas Insurance Code Section 1661.002(b).
[34] Chicago Tribune, "Why don't more people shop for health care? Online tools exist, but most don't use them." July 20, 2018, retrieved from http://www.chicagotribune.com/business/ct-biz-hospital-price-transparency-0722-story.html.
[35] Senate Bill 507, 85th Regular Session (Hancock/Frullo), 2017.
[36] Dallas Morning News, "That freestanding emergency room is probably not in-network, no matter what the website says." February 26, 2018.
[37] Texas Association of Health Plans, *Legislative Solutions to Better Protect Texans in Emergency Medical Situations*, March 2017.
[38] Texas Insurance Code Section 1451.505(d).
[39] House Bill 336, 85th Regular Session (Collier), 2017.
[40] Senate Bill 2064, 85th Regular Session (Hancock), 2017.

Interim Charge 6A: Mental Health Implementation

Interim Charge Language: *Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services, 85th Legislature, and make recommendations for any legislation needed to improve, enhance, and/or complete implementation, including but not limited to initiatives to increase capacity and reduce waitlists in the mental health system, including the construction of state hospitals and new community grant programs.*

Hearing Information

The Senate Health and Human Services Committee held a hearing on September 12, 2018 to discuss Interim Charge 6a. Individuals representing the Health and Human Services Commission (HHSC) provided invited testimony.[1]

Behavioral Health Matching Grants[2]

Two pieces of legislation passed by the 85th Legislature created mental health matching grant programs to address gaps in services at the local level. One program (SB 292,85R) focuses on reducing recidivism, arrest, and incarceration of individuals with mental illness, while the other (HB 13, 85R) focuses on a broader range of community services such as reducing homelessness and substance use. Urban counties must match the grant funds at 100 percent and rural counties must match at 50 percent.

Senate Bill 292--85R (Huffman/Price)

Senate Bill 292 created a program to reduce recidivism, arrest, and incarceration of individuals with mental illness and reduce forensic commitment wait times by providing grants to county-based community collaboratives. A community collaborative includes a county, a Local Mental Health Authority (LMHA) operating in the county, and each hospital district located in the county.

The grant program was appropriated $37.5 million through Rider 82. Awardees for Fiscal Years (FY) 2018-2019 include 14 urban and 10 rural LMHAs and Local Behavioral Health Authorities (LBHAs). Examples of projects include Forensic Assertive Community Treatment Teams, Jail-Based Competency Restoration Programs, and local community hospital, crisis, respite, or residential beds.

House Bill 13--85R (Schwertner/Price)

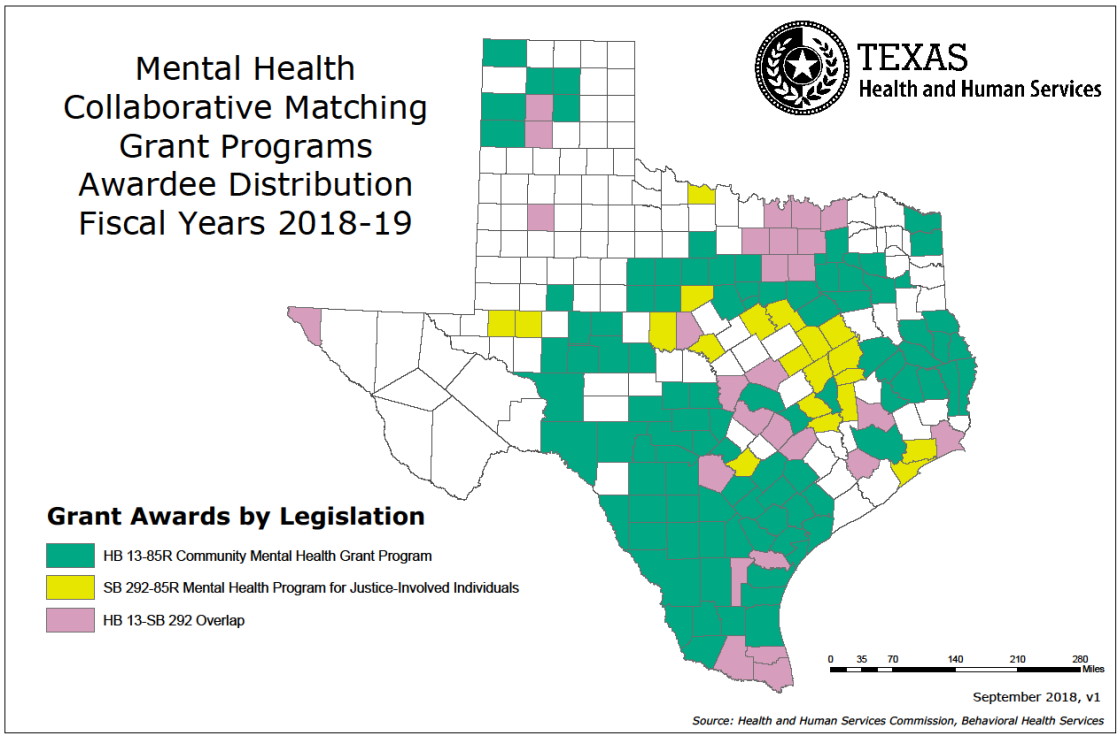
House Bill 13 created a program to provide matching grants to support community mental health programs providing services and treatment to individuals experiencing mental illness. Grantees must foster community collaboration, maximize existing community mental health resources, and strengthen continuity of care for individuals receiving services through a diverse network of local providers.

Funds are being awarded in two phases using distinct procurement methods: Needs and Capacity Assessment (NCA) distributed to LMHAs and LBHAs, and Request for Applications (RFA) distributed to governmental entities and non-profit organizations. The program was appropriated $30 million through Rider 83:

- *FY18* - $5 million through NCA and $5 million through RFA
- *FY19* - $10 million through NCA and $10 million through RFA

Twenty-five LMHAs/LHBAs have been identified as apparent awardees through NCA, 16 of which have rural service areas. Through RFA, 31 non-profit organizations and government entities have been identified as apparent awardees--seven of which have rural service areas. Projects address gaps outlined in the Statewide Behavioral Health Strategic Plan, such as access to appropriate behavioral health services, access to timely treatment services, or behavioral health needs of public school students.

HB 13 and SB 292 Apparent Awardees[3]



Contract Execution

Contract execution for the grants was delayed in Spring 2018 due to Hurricane Harvey and agency-wide procurement issues. Some contracts have already been executed, and HHSC expects all contracts to be signed by the end of the first quarter of FY19.

State Mental Health Hospitals

There is a need for increased capacity in the state's mental health hospital system, especially in the forensic space. The forensic population made up 28 percent of the state hospital population in fiscal year 2006 compared to 61 percent in FY18.[4] The current state hospital waitlist is also dominated by those with a forensic designation, including maximum security.

Waiting List	Total Number Waiting	Number Waiting >21 days (forensic) or >14 days (civil)
Max Security (MSU)	453	432
Forensic, non-MSU	268	161
Civil	102	55
Total	**823**	**648**

*Waitlist as of October 26, 2018[5]

To address the waitlist and the need for greater continuity of care, the 85th Legislature appropriated $300 million for the construction and renovations of state hospitals.[6] The funding is contingent upon HHSC creating a three-phase comprehensive inpatient mental health plan to expand inpatient capacity and improve behavioral health service delivery over the next three biennia. The plan is available on HHSC's website: https://hhs.texas.gov/about-hhs/process-improvement/changes-state-hospital-system

State Hospital Plan - Phase 1

HHSC plans to add 338 inpatient mental health beds with the $300 million appropriated by the 85th Legislature.[7] Projects and costs include:

Project	Cost	New Beds
Austin State Hospital Planning	$15.5M	TBD
Kerrville State Hospital Planning and Renovation	$30.5M	70 MSU Beds
Rusk State Hospital - Maximum Security Hospital Planning and Construction Rusk State Hospital - Non Maximum Security Hospital Planning	$91.5M $4.5M	60 MSU Beds
San Antonio State Hospital - Civil Renovation San Antonio State Hospital - Planning	$11.5M $14.5M	40 Civil Beds TBD
Harris County Psychiatric Center - Planning and Construction	$125M	228+ Civil and Non-Max Forensic Beds

It is important to note that the costs above do not include operational costs. For example, the increased capacity at Kerrville and San Antonio State Hospitals will be completed by the next budget cycle. HHSC is asking for additional funding to operate these beds in their Legislative Appropriations Request. The Legislature should keep ongoing operational costs in mind when determining project funding in the future.

Recommendations

1. **Continue monitoring the implementation of the behavioral health matching grants passed by the 85th Legislature, including contract execution.**

2. **The Legislature should continue to build on the investments made in the state's inpatient mental health system by completing the projects initiated last Legislative session.**

3. **HHSC should continue collaborations with state health-related institutions to maximize workforce development and integrated care.** The $300 million appropriated was not intended to just add capacity in the system, but also to ensure continuity of care across the entire behavioral health delivery system to reduce re-hospitalization rates. Continuity of care should focus on services available to an individual when they are released from the state hospital system and options to prevent them entering the system. This effort will involve buy-in from the criminal justice system, Local Mental Health Authorities, law enforcement, and other community partners. Collaborations with health-related institutions should assist with maximizing treatment options, growing the behavioral health workforce, and increasing quality of care.

4. **HHSC and the Legislature should consider options that ensure capacity in rural areas of the state.** This could include increased purchased beds at private facilities in counties located a certain distance from a state hospital or expanding the STARCARE, Lubbock County's LMHA, model that currently exists in the panhandle. STARCARE has operated a jail diversion program in Lubbock County since 1999 via a Memorandum of Understanding (MOU) with the Lubbock County Sheriff's Department and additional agreements with the Lubbock County Juvenile Justice Center. Their model, which utilizes the 30 bed Sunrise Canyon Psychiatric Facility to provide intensive inpatient care in lieu of a jail or state hospital, has produced positive results and avoided costs.

5. **The Legislature and relevant agencies should ensure behavioral health care is available to children.** The Select Committee on Violence in Schools and School Security studied the availability of behavioral health services available to students and recommended a number of ways to address gaps in care. The Legislature should consider implementing their recommendations. Additionally, current grant programs could be tailored to focus on the needs of children. For example, a portion of the HB 13 dollars were awarded to Texas Tech Health Science Center for the expansion of their school based telehealth program, TWITR.

6. **The Legislature should adopt relevant recommendations made by the Judicial Commission on Mental Health that impact the state hospital waiting lists.** The Judicial Commission on Mental Health was created to develop, implement, and coordinate policy initiatives designed to improve the courts' interaction with children, adults, and families with mental health needs.[8] It is the judicial system that makes forensic designations and opportunities exist to make appropriate changes in the legal system that will have a positive impact on the inpatient waitlist. For example, in September 2018, the Texas Judicial Council adopted a resolution containing twelve legislative recommendations related to mental health and the judicial system. Recommendations include granting the courts discretion when initially committing an individual to a max security unit rather than mandating all individuals with a certain offense be committed to max security.

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List*, September 12, 2018.
[2] Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services.* September 12, 2018.
[3] Information provided by the Health and Human Services Commission.
[4] *Supra* note 2.
[5] *Supra* note 3.
[6] Senate Bill 1, 85th Regular Session, Rider 147, 2017.
[7] *Supra* note 1.
[8] Texas Judicial Commission on Mental Health Homepage, http://www.txcourts.gov/jcmh/, September 17, 2018.

Interim Charge 6B: Maternal Mortality and Morbidity Implementation

Interim Charge Language: *Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services, 85th Legislature, and make recommendations for any legislation needed to improve, enhance, and/or complete implementation, including but not limited to initiatives to better understand the causes of maternal mortality and morbidity including the impact of legislation passed during the first special session of the 85th legislature. Recommend ways to improve health outcomes for pregnant women and methods to better collect data related to maternal mortality and morbidity.*

Hearing Information

The Senate Health and Human Services Committee held a hearing on September 12, 2018 to discuss Interim Charge 6b. Individuals representing the Department of State Health Services (DSHS) and the Health and Human Services Commission (HHSC) provided invited testimony.[1]

Maternal Mortality and Morbidity Task Force

The Task Force, established by the 83rd Legislature, is a multidisciplinary group tasked with studying maternal mortality and morbidity in Texas. The Task Force provides critical information on maternal mortality trends and demographics.

Senate Bill 17--85(1) (Kolkhorst/Burkett)

Senate Bill 17 extended the Task Force's Sunset date from 2019 to 2023, directed DSHS to develop a maternal health and safety initiative, and required DSHS and HHSC to conduct a number of studies related to cause of death data, maternal mortality in the Medicaid program, and options for addressing maternal mortality and morbidity. The bill also added additional criteria for the Task Force to study; specifically rates and disparities in maternal mortality, including populations most at risk.[2]

Maternal Mortality and Morbidity Task Force and DSHS Joint Biennial Report

The 2018 Maternal Mortality and Morbidity Task Force and DSHS Joint Biennial Report was released August 21, 2018. In developing the report, the Task Force reviewed all cases of maternal death in the 2012 calendar year, and studied trends for deaths within 42 days postpartum and 365 days postpartum.[3] The report contains findings from these Task Force case reviews, and statewide trends for maternal death, including most at-risk populations, along with Task Force recommendations to help reduce the incidence of pregnancy-related deaths and severe maternal morbidity in Texas. The Task Force found that[4]:

- Nearly 40 percent of maternal death cases reviewed were identified as pregnancy-related.
- The leading causes of pregnancy-related death in 2012, included cardiovascular and coronary conditions, obstetric hemorrhage, infection/sepsis, and cardiomyopathy.
- The majority of maternal deaths in 2012 were women enrolled in the Medicaid program at the time of delivery.
- Most pregnancy-related deaths were potentially preventable.
- A complex interaction of personal, provider, facility, systems, and community factors contributed to maternal death.

- Delays in receiving case records and the redaction process slowed maternal death case review.
- Hemorrhage and cardiac events were the two most common causes of death while pregnant or within seven days postpartum.
- The majority of maternal deaths occurred more than 60 days postpartum.
- From 2012 to 2015, drug overdose was the leading cause of maternal death from delivery to 365 days postpartum.*
- Black women:
    - were more likely to experience pregnancy-related death in 2012;
    - bear the greatest risk for maternal death, regardless of income, education, marital status, or other health factors; and
    - are at a higher risk of severe maternal morbidity involving obstetric hemorrhage.
- Obstetric hemorrhage:
    - was the leading cause of severe maternal morbidity; and
    - rates varied by county.

To read the Task Force recommendations, download the report, available on the DSHS website: https://www.dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm

DSHS Study: Enhanced Method for Identifying Maternal Deaths

A 2016 study published in the journal *Obstetrics and Gynecology* suggested an unprecedented increase in the rate of maternal deaths in Texas between 2010 and 2012.[5] As part of efforts to understand and address maternal mortality, DSHS researchers evaluated the accuracy of the data used in this study. In April of 2018, they published a study showing the number of maternal deaths occurring within 42 days postpartum was less than half the number previously reported--56, rather than 147.[6]

In reaching these findings, the researchers developed an enhanced method to verify maternal deaths by cross-referencing birth certificates, death certificates, and medical records, and found that dozens of women were erroneously identified on their death certificates as being pregnant at the time of death. It appears that the individuals who certified the deaths inadvertently selected the wrong option from the dropdown menu for pregnancy status. From 2010 - 2012, the proportion of death certificates filed electronically grew by 44 percent, which could explain the perceived increase in maternal deaths.[7] This new enhanced method will be used in all future Texas analyses, beginning with 2013 data. This will result in greater certainty about the numbers reported by the state.[8]

In response to the 2018 study, DSHS is developing an updated vital registration system that will include an extra verification step prompting the user to confirm a pregnancy status before submitting a death record. The agency is also developing new training resources for medical death certifiers.[9]

*For more information on drug overdose and maternal mortality, see the Committee's report on Substance Use Disorders and Opioids

TexasAIM Initiative

DSHS partners with the Alliance for Innovation on Maternal Health (AIM) to reduce severe maternal morbidity using evidence-based systems to enhance maternal care. An AIM Maternal Safety Bundle is a collection of best practices for improving maternal care. Current bundles address obstetric hemorrhage and severe hypertension in pregnancy, and a bundle on obstetric care for women with Opioid Use Disorder began its pilot program in September 2018.There are currently 184 birthing hospitals enrolled in the *TexasAIM* initiative, representing 80 percent of all births in Texas.[10]

House Bill 2466--85R (Davis, S./Huffman)

This bill requires Medicaid and the Children's Health Insurance Program (CHIP) to cover a maternal depression screening for the mother of an enrollee. As of July 1, 2018, Medicaid covers screenings conducted at an infant's Texas Health Steps checkup.

Upcoming Reports--Due by December 1, 2018

- DSHS study on cause of death data issues related to maternal mortality. Required by Senate Bill 17. Released in November 2018.[11]
- DSHS report on the Maternal Safety Initiative (*TexasAIM* Initiative). Required by Senate Bill 17.
- HHSC study on feasibility of tying *TexasAIM* to quality indicators and quality-based payment initiatives in the Medicaid program. Required by Senate Bill 17.
- HHSC report on options for addressing the top causes of maternal mortality, including options for treating post-partum depression in economically disadvantaged women. The report will also include options for lowering costs and improving quality related to maternal morbidity in Medicaid and report on the Commission's efforts. Required by Senate Bill 17.
- Maternal and Neonatal Health, HHSC Rider 40. This will include identified opportunities for decreasing Neonatal Intensive Care Unit costs in Medicaid/CHIP via Better Birth Outcomes initiatives, and identify strategies to prevent neonatal abstinence syndrome and reduce maternal mortality.

Conclusion

While the study published in April 2018 clarified that Texas is not an outlier in maternal mortality rates, findings from the Task Force and DSHS report demonstrate that the state should continue to prioritize better understanding the causes of maternal mortality and morbidity, along with developing and implementing solutions to protect mothers.

Recommendations

1. **Continue to support the rollout of the *TexasAIM* Initiative and other efforts to improve maternal health and safety.** Given that the leading cause of maternal death after 60 days was drug overdose, the pilot for the AIM Bundle on Obstetric Care for Women with Opioid Use Disorder should be closely monitored to prepare for effective statewide implementation.

2. **Strengthen practices surrounding risk assessment and appropriate referral during pregnancy, delivery.**

3. **Strengthen the maternal death review process.** A majority of the cases reviewed by the Task Force were found to have an inaccurate pregnancy status marker on the death certificate. Improvements should include education for death certifiers as well as coding fixes to reduce human errors.

4. **Ensure maternal health programming targets high-risk populations, especially Black women.** The Task Force found that Black women were the most likely to experience pregnancy-related death, regardless of socioeconomic level.

[1] Senate Committee on Health And Human Services, *Interim Hearing Witness List*, September 12, 2018.
[2] Senate Bill 17, 85th Session, First Called (Kolkhorst/Burkett), 2017.
[3] *Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report*, September 2018.
[4] *Supra* note 3.
[5]MacDorman et al, "Is the United States Maternal Mortality Rate Increasing? Disentangling trends from measurement issues Short title: U.S. Maternal Mortality Trends." *Journal of Obstetrics an Gynecology*, 2016.
[6] Beava et al, "Identifying Maternal Deaths in Texas Using an Enhanced Method, 2012." *Journal of Obstetrics and Gynecology*, 2018.
[7] Information provided by DSHS.
[8] Department of State Health Services. *Testimony before the Senate Committee on Health and Human Services.* September 12, 2018.
[9] *Supra* note 7.
[10] *Supra* note 7.
[11] Department of State Health Services. *Improving the Quality of Cause of Death Information Related to Maternal Mortality*. November 2018.

Interim Charge 6C: Child Protective Services Implementation

Interim Charge Language: *Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services, 85th Legislature and make recommendations for any legislation needed to improve, enhance, and/or complete implementation, including but not limited to initiatives intended to improve child safety, Child Protective Services workforce retention, and development of additional capacity in the foster care system. Make additional recommendations to ensure children with high levels of medical or mental health needs receive timely access to services in the least restrictive setting.*

Hearing Information

The Senate Health and Human Services Committee held a hearing on September 12, 2018 to discuss Interim Charge 6C. Individuals representing the Department of Family and Protective Services (DFPS) as well as Superior Health Plan provided invited testimony.[1]

Background

The 85th Texas Legislature passed wide-sweeping legislation to reform multiple parts of the Department of Family and Protective Services (DFPS). While many areas were addressed by the Legislature, a specific focus was to address the capacity crisis present in the foster care system. Ensuring there is enough capacity to serve all children in foster care is extremely complex and is an ever-moving, evolving target. Common trends over the last few years demonstrate that the acuity level of children in foster care continues to increase as more children are diverted from foster care to kinship care and other placements, and an increased focus on ensuring children are placed in the least restrictive setting creates a growing need for more foster homes with specialized services and supports.

There are approximately 30,000 children and youth in care of DFPS annually.[2] The capacity level is in constant flux, however there is a current licensed capacity of just over 31,000 foster home placements and over 35,000 placements in non-family like settings such as congregate care.[3] However, these numbers are ever-changing, and in general the number of licensed placements has decreased over the past year. While total foster homes have increased by eight percent over the last year, the addition of new foster homes has decreased.[4] Since 2016, Texas has increased the number of faith-based partnerships in an effort to increase the number of foster homes as well as supports for foster families. However, DFPS does not track the number of foster families that are recruited from these partnerships. As mentioned earlier in the report, currently, there are 1,314 church partnerships statewide, with 30 new partnerships occurring in July 2018.[5]

Removal rates of children continues to increase annually with more children being removed and placed in foster care than exiting the system. For example, in July 2018, there were 1,585 children removed from their homes with only 1,457 children exiting care. However, the average months to exit from conservatorship is decreasing from 19.2 months in July of 2018 compared to 21.1 months in July of 2017. Finally, children sleeping in hotels and offices as of August 2018 was around 60 kids statewide in comparison to earlier this year within between 15 to 30 kids statewide.[6]

Child Specific Contracts

Child Specific Contracts are another tool utilized by DFPS to ensure children and youth in care have a placement when there is no other alternative. Children that need these contracts executed have been in institutional settings such as psychiatric hospitals or Residential Treatment Centers (RTCs). Providers request these contracts in order to secure funds for more difficult to treat children, or for children who no longer need their care but DFPS cannot secure another placement. An example is a child who had been placed in a psychiatric hospital for treatment but no longer needs intensive services. These contracts are expensive and many times continue placing a child in a restrictive setting when he or she no longer needs institutionalized or higher level care. The total cost for these contracts has hovered around $25 million annually, but the number of contracts executed continues to rise.[7]

Legislative Changes

As previously mentioned, the 85th Legislature attempted to address capacity in numerous ways to decrease the number and cost of child specific contracts and to ensure children are placed in a least restrictive environment that is in the best interest of that child. To do this, the Legislature funded a number of initiatives, including:

Treatment Foster Care

This program is specifically for children aged ten and younger who would in the past require a stay in a RTC. Instead, this program diverts these children from institutionalized services by placing them in a therapeutic foster home with wraparound services and supports. Foster parents receive specialized training in order to participate in this program. Three contracts have been awarded in Dallas, Houston, and San Antonio, and have just begun serving children.[8]

Intense Plus Rate

The Legislature funded a higher level of care for children and youth requiring complex case management and specialized services. This new rate called the intense plus rate is available only in RTCs. One contract has been awarded, and DFPS is actively searching for more RTCs with which to contract.[9]

Foster Care Rate Increase

The Legislature funded rate increases for foster care providers at 95 percent of the cost of care.[10]

Capacity Needs Assessment

Senate Bill 11 (85R, Schwertner) requires DFPS to complete an annual capacity needs assessment to be utilized by local communities to grow regional capacity, thereby ensuring children who are placed in foster care remain in their home community.[11] The 2018 assessment was completed in August of 2018 by DFPS and is currently being utilized by all regional staff and stakeholders to strategically build local capacity.[12] Once these plans are finalized, they will be posted on the DFPS website.

Medical Exams

Children who enter the foster care system have all experienced some form of trauma and have a higher chance of requiring medical or behavioral health intervention. Over the past few years, the Legislature has taken an amplified look at the services and supports children receive in foster care. Specifically, providers need to know what individualized services a child needs. To do this, multiple policy changes have been recently implemented.

Three Day Medical Exam

This exam was an added requirement put in place by Senate Bill 11 (85R, Schwertner) for all children who enter care that are removed as the result of sexual abuse, physical abuse, or an obvious physical injury to the child; or has a chronic medical condition, a medically complex condition, or a diagnosed mental illness. DFPS, in consultation with HHSC nad STAR Health, implemented this exam statewide for all children who enter care to ensure that immediately upon entry into the foster care system, providers know what services a child needs. This policy has already rolled out statewide.[13]

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Exam

In 2016, this Committee learned that while it is contractually required that the Superior HealthPlan ensure all foster children receive an EPSDT exam within 30 days of entering care, only approximately 50 percent received this exam within 30 days.[14] To address this, Senate Bill 11 (Schwertner, 85R) adds that monetary penalties should be assessed against Superior and the Child Placing Agency in charge of a child's care if this exam is untimely or fails to occur.[15] Monetary penalties were implemented for CPAs beginning September 1, 2018, and penalties will begin in March. In addition, HHSC will monetarily penalize Superior if DFPS proves to HHSC that the reason a child did not get a timely EPSDT is due to network inadequacy.[16]

Child and Adolescent Needs and Strengths Assessment (CANS)

Senate Bill 125 (West, 84R) required all children who enter the foster care system to receive a CANS assessment.[17] This assessment tool is a comprehensive trauma-informed behavioral health evaluation and communication tool intended to prevent duplicate assessments, decrease unnecessary psychological testing, aid in identifying placement and treatment needs, and inform case planning decisions. CANS assessments help decision-making, drive service planning, facilitate quality improvement, and allow for outcomes monitoring. DFPS implemented this, requiring in policy that this assessment occur within 30 days, however, only 30 percent of children receive this assessment within that timeframe.[18]

Recommendations

1. **In total, 97 bills were passed in the 85th Legislative Session that affected DFPS, and many required substantial reform. While continuing to look for areas of improvement, the Legislature should not duplicate past efforts when addressing CPS during the 86th Legislative Session to allow time for DFPS to implement the many important changes that have been legislatively directed over recent years.**

2. **While the Texas Legislature funded and directed many positive programs and improvements directed at increasing capacity in the Child Protective Services system, most of these programs have not had enough time to produce outcomes. The Legislature should continue monitoring these programs.**

3. **The acuity level of children in the foster care system continues to increase, and measures to ensure all children in care receive necessary services and supports should continue to be addressed by the Legislature.**
   - The CANS assessment is only given within 30 days to 30 percent of children in care. All children should be receiving this assessment within 30 days.
   - The EPSDT exam is only given to around 50 percent of children in foster care within 30 days. All children should be receiving this assessment within 30 days.

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List*, September 12, 2018.
[2] Department of Family and Protective Services 2017 Data Book.
[3] Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, September 12, 2018, slide 3.
[4] Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, September 12, 2018.
[5] Information provided by the Department of Family and Protective Services via email, August 28, 2018.
[6] Information provided by the Department of Family and Protective Services via email, August 28, 2018.
[7] Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, September 12, 2018, slide 12.
[8] Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services.* September 12, 2018, slide 11.
[9] *Supra* note 3.
[10] Legislative Budget Board, 2017-2018 Texas Budget.
[11] Senate Bill 11, 85th Regular Session (Schwertner/Frank), 2017.
[12] *Supra* note 8.
[13] Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, September 12, 2018, slide 17.
[14] Information provided by Superior HealthPlan via email, September 10, 2018.
[15] *Supra* Note 11.
[16] Information provided by the Department of Family and Protective Services via telephone meeting, August 23, 2018.
[17] Senate Bill 125, 84th Regular Session (West/Naishtat), 2015.
[18] *Supra* Note 14.

Interim Charge 6D: Community Based Care Implementation

Interim Charge Language: *Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services, 85th Legislature and make recommendations for any legislation needed to improve, enhance, and/or complete implementation, including but not limited to efforts to transfer case management of foster children and families to Single Source Continuum Contractors (SSCCs). Monitor the progress of this transition and make recommendations to ensure the process provides continuity of services for children and families and ongoing community engagement.*

Hearing Information

The Senate Health and Human Services Committee held a hearing on September 12, 2018 to discuss Interim Charge 6D. Individuals representing the Department of Family and Protective Services (DFPS) as well as ACH Child and Family Services provided invited testimony.[1]

Background

During the 85th Legislative Session, the Texas Legislature prioritized reforming the Child Protective Services (CPS) system to ensure children and families that interface with this system are provided appropriate, high-quality services and supports which lead to positive outcomes for children and families. One major piece of legislation, Senate Bill 11, reformed the statewide foster care model, instead requiring local entities and communities to take responsibility and be accountable for foster care children in their regions and communities. This new model, known as Community Based Care, reforms the Foster Care Redesign model that has been in place in the Arlington area since 2014.

Main proponents of the Foster Care Redesign model included a "no eject, no reject" clause within the contract with the Single Source Continuum Contractor (SSCC). This ensures children in a region remain in that region, and that the SSCC provides care to all children within its geographical purview. In addition, an SSCC is held accountable through a performance-based contract. While Foster Care Redesign required an entity to assume responsibility of placement of children in foster care in appropriate living arrangements, Community Based Care adds additional responsibilities including case management and reunification services for children in care in addition to the Foster Care Redesign contractual requirements and model.

Community Based Care has three stages. These three stages are:

- **Stage I**: SSCC is responsible for placement of children in foster homes and other living arrangements as appropriate with a "no eject, no reject" clause and performance-based contract
- **Stage II:** SSCC is responsible for full case management and reunification services that move children to permanency
- **Stage III:** SSCC performance metrics inform incentives and penalties for the time a child spends in foster care[2]

While the Legislature funded five areas of Community Based Care, only one region is currently providing services, with two others scheduled to begin providing services this winter. Implementation of Foster Care Redesign since 2014 has been slow, and the 85th Texas Legislature signaled through funding five catchment areas, that the rollout of this model should rapidly increase.[3]

Outcomes of Community Based Care

Outcomes of children placed in a Community Based Care catchment area are positive, and demonstrate that this model is appropriate and effective. Outcomes are currently limited to Region 3b, and include:

- More children are in their own community due to the no eject, no reject clause of this model and contract provision.
- There has been a drastic increase in foster care capacity.
- There has been a drastic increase in therapeutic capacity.
- More children are in family settings instead of institutions.
- Placement stability has improved.[4]

The addition of two catchment areas providing Community Based Care will not only provide additional outcome data for children in each respective area, but will also demonstrate differences in a community and how the model is implemented in each community. This will demonstrate best practices and novel approaches specific to each community's needs.

Evaluating CBC

The Committee applauds DFPS' willingness and motivation to evaluate Community Based Care. Specifically, DFPS is contracting with Texas Tech University to produce an evaluation report on the implementation process in each of the catchment areas for Stages I and II to look at ways to strengthen the model and rollout of each stage. In addition, DFPS is contracting with Chapin Hall of the University of Chicago to provide independent data analysis of each SSCC's performance on paid foster care days, to evaluate the SSCCs performance-based contract and blended payment structure, and look overall at payment methodology for the SSCC.[5]

Legislative Oversight

The addition of case management and reunification services in Phase II must continue to be overseen by both stakeholders and the Legislature, to ensure a smooth rollout of services for children and families impacted. Specifically, the Legislature should focus on:

- Ensuring that the transfer of data between DFPS and the SSCC is seamless. Senate Bill 11 established a data governance council to advise DFPS on this issue to ensure case records and data are housed at both the SSCC and state.
- Ensuring appropriate capacity for youth in the area is strengthened, especially for high acuity children and youth.
- Overseeing how an SSCC is reimbursed to ensure the provision of high quality, individualized care to every child.

- Overseeing how DFPS manages contract compliance with each SSCC as well as conducts case reads of children served under the Community Based Care model.

Recommendations

1. **The Legislature should continue the expansion of Community Based Care.**
   The speed at which this model rolls out must continue to be driven by the Legislature, and measures of performance and contractual requirements should continue to be a discussion.

2. **DFPS and HHSC should review future reports and recommendations on how to best structure the rate methodology and payment structure for operation of an SSCC.**

3. **DFPS should begin structuring Stage III contracts to ensure SSCCs are held accountable for children and families that are being served.**
   While no SSCC is currently in Stage III regarding the provision of services in Community Based Care, DFPS should begin working with the Legislature and stakeholders to structure these contracts.

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List,* September 12, 2018.
[2] Department of Family and Protective Services, *Testimony before the Senate Health and Human Services Committee,* September 12, 2018, page 2.
[3] Department of Family and Protective Services, *Testimony before the Senate Health and Human Services Committee,* September 12, 2018, page 3.
[4] Department of Family and Protective Services, *Testimony before the Senate Health and Human Services Committee,* September 12, 2018, page 7.
[5] Department of Family and Protective Services, *Testimony before the Senate Health and Human Services Committee,* September 12, 2018, page 11.

Interim Charge 6E: Long-term Care Implementation

Interim Charge Language: *Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services, 85th Legislature and make recommendations for any legislation needed to improve, enhance, and/or complete implementation, including but not limited to initiatives to strengthen oversight of long-term care facilities to ensure safety and improve quality for residents and clients of these entities.*

Hearing Information

The Senate Health and Human Services Committee held a hearing on September 12, 2018 to discuss Interim Charge 6E. Individuals representing the Health and Human Services Commission (HHSC) provided invited testimony.[1]

House Bill 2025

In 2014, the Sunset Commission found that the Department of Aging and Disability Services (DADS) which is responsible for regulating long-term care entities is limited in how it can enforce these regulations. A combination of low penalty caps, extensive right-to-correct provisions, and a lack of progressive sanctions hindered DADS' ability to utilize administrative penalties as a deterrent for failure to comply with minimum standards. Senate Bill 204 (Hinojosa, 84R) attempted to address these concerns, but the bill failed to pass.[2]

In many cases, long-term care facilities are regulated by both state and federal authorities at a level sufficient to ensure the health and safety of residents and clients. For providers, changes in agency policies and procedures are delivered in an uncoordinated, confusing, and ad-hoc manner without sufficient opportunity for stakeholder questions or input. Senate Bill 932 (Schwertner, 85R) attempted to address these concerns. Below are past issues that were addressed in the 85th Texas Legislative Session.[3]

Progressive Sanctions

In their 2014 review of DADS, Sunset found that DADS failed to adequately track violations and the scope and severity of those violations. Prior to House Bill 2025 (85R, Davis, Y./Schwertner), only nursing facilities had a scope and severity scale, which is based on federal law, to allow surveyors to accurately track and distinguish between violations; only Intermediate Care Facilities (ICF/IID) had a penalty matrix that tied increased penalty amounts to second and third offenses. House Bill 2025 required HHSC to create a matrix of progressive sanctions to record and track the scope and severity of violations for all long-term care providers in order to assess the appropriate enforcement action and deter future violations.[4]

Penalty Caps

Low caps on the total penalty per violation or per inspection has the potential to make penalties simply a cost of doing business. To address this, House Bill 2025 removed certain provider violation caps to ensure providers are appropriately penalized for a violation.

- **Intermediate Care Facilities (ICFs/IID):** Prior to House Bill 2025, penalty caps for a single violation range from $1,000 per violation, per day, for facilities with fewer than 60 beds to $5,000 per violation, per day, for facilities with 60 or more beds. House Bill 2025 removes the total amount cap of $5,000 for a facility less than 60 bed and $25,000 for a facility with 60 beds or more, for a continuing violation occurring on separate days.

- **Assisted Living Facilities (ALFs):** Administrative penalties were capped at $1,000, and there is no authority to apply a per-day penalty. House Bill 2025 removed the cap of $1,000, increasing that cap to $5,000 for a violation that represents a pattern that results in actual harm, is widespread and results in actual harm, or constitutes an immediate threat to the health and safety of a resident.

- **Home and Community Support Services (HCSSAs):** The highest administrative penalty caps are $1,000 per violation, per day, even for a violation resulting in serious harm or death of a patient. Senate Bill 933 (Schwertner, 85R) attempted to remove the $1,000 cap, increasing that cap to $5,000. However, this bill failed to pass.

- **Home and Community-based Services (HCS):** Senate Bill 1385 (84R, Schwertner*)* gave HHSC the ability to assess administrative penalties of $100-$5,000 per violation and allowed progressive sanctions for repeated violations. In addition, House Bill 2590 (Raymond, 85R) aligned HCS providers with all other long-term care providers whose regulatory policies and procedures were changed in House Bill 2025 by requiring the same no right to correct for violations for actual harm and immediate threat. [5]

Right to Correct

Prior to House Bill 2025, in general, all licensed providers are granted 45 to 60 days to correct violations without being assessed an administrative penalty unless the violation:

- results in serious harm or death to a client;
- constitutes an actual serious threat to the health and safety of a client;
- substantially limits the entity's ability to provide care; or
- involves one of the following:
    - provider making a false claim to DADS in their application for licensure or renewal;
    - refusal of the provider to allow a DADS representative to inspect a facility or records;
    - provider willfully interfering with the work of a DADS representative;
    - failure to notify DADS of change of ownership in a timely manner; or
    - failure to pay an assessed penalty within 30 days.[6]

House Bill 2025 removed the opportunity for providers to utilize right-to-correct for violations that represent an immediate treat to the health and safety of a resident, result in actual harm to a resident, unless it is an isolated incident, or constitutes the potential for widespread actual harm for all long-term care provider types. [7]

Timeline for House Bill 2025

Rules drafted by HHSC were made available to stakeholders on January 26, 2018 and a follow-up meeting to address stakeholders concerns occurred in February 2018. These rules were effective October 28, 2018. [8]

Recommendations

1. **Continue to monitor implementation of long-term care regulation legislation to ensure HHSC implements changes in a way that is less burdensome on providers.**

2. **Monitor surveyors' consistency and ensure that providers understand what is expected of them.**

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List,* September 12, 2018.
[2] Sunset Advisory Commission, *Department of Aging and Disability Services Staff Report with Final Decisions,* Chapter 4, July 2015.
[3] Department of Aging and Disability Services and Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services,* February 18, 2016.
[4] *Supra* note 1.
[5] House Bill 2025, 85th Regular Session (Davis, Y., Schwertner, 2017).
[6] 40TAC 90.240; 40TAC 90.105€; 40TAC 19.2114; 40TAC 97.602©; 40 TAC 92.551(g).
[7] *Supra* Note 5.
[8] Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services,* September 12, 2018, pages 3 and 4.

Interim Charge 6F: Abortion Reporting Implementation

Interim Charge Language: *Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services, 85th Legislature, and make recommendations for any legislation needed to improve, enhance, and/or complete implementation. Specifically, abortion complications and other reporting legislation that was passed by the 85th Legislature.*

Hearing Information

The Senate Health and Human Services Committee held a hearing on September 12, 2018 to discuss Interim Charge 6f. Individuals representing the Health and Human Services Commission (HHSC) provided invited testimony.[1]

Background

Three pieces of legislation passed by the 85th Legislature altered abortion reporting requirements for the State of Texas. Together, these pieces of legislation seek to improve the women's health system by promoting transparency, increasing safety, and ensuring accountability.

Senate Bill 8--85R (Schwertner/Burkett)
Senate Bill 8 requires the dignified disposition of embryonic and fetal tissue remains, amends the definition of abortion, requires physicians, instead of facilities, to report all abortions performed, and requires reporting of fetal tissue donations by ambulatory surgical centers, birthing centers, and hospitals.

A temporary injunction was issued in January 2018 as a result of *Whole Woman's Health v. Smith* (1: 16-cv-01300, W.D. Tex.), preventing the dignified disposition requirement from going into effect. A full trial on the merits was held in July 2018. In September 2018 the U.S. District Court for the Western District of Texas ruled in favor of Whole Women's Health, finding the dignified disposition requirement to be unconstitutional. The Attorney General's Office has appealed to the Fifth Circuit. The first brief in fetal remains is due November 19. The case will likely not be argued until next summer, either May or June.

In August 2017, the Western District of Texas temporarily enjoined the dismemberment abortion ban to prevent it from going into effect in *Whole Woman's Health v. Paxton* (1:17-cv-00690). After a full trial on the merits in November 2017, the court struck down the ban as unconstitutional. The Attorney General's Office appealed the ruling to the Fifth Circuit, where it has been fully briefed and was be argued before a three-judge panel in New Orleans on November 5, 2018.[2]

House Bill 13--85-1 (Capriglione/Campbell)
House Bill 13 expanded abortion complication reporting requirements to include certain health care facilities as well as physicians. General rules for abortion facilities were adopted in May 2018. Ambulatory Surgical Centers and hospital rules were adopted in September 2018 and freestanding ER rules are expected to be adopted in March 2019.[3]

House Bill 215--85-1 (Murphy/Hughes)
House Bill 215 expanded information which must be reported for abortions performed on minors and any abortions performed in the third trimester. Rules were adopted in May 2018.

Reporting Mechanisms

HHSC has been working to design an electronic reporting system that satisfies all statutory reporting requirements, meets ongoing regulatory needs, and reduces inefficiencies associated with the current manual process. Initial research conducted by HHSC indicates that an electronic system must include the following:

- Secure access for users and staff
- The ability to confirm reports are complete prior to submission and verify accuracy of some fields
- Document upload capability
- Flexible reporting capable of meeting recurring and ad-hoc reporting needs
- Ability to monitor compliance with reporting deadlines and generate referrals as appropriate
- Provision of ongoing technical support to both internal users and end users

Additionally, HHSC has stated that the electronic reporting system will allow agency regulatory services prompt access to reported information, which will enhance and streamline enforcement of the requirements as outlined in statute. The reporting system will also be located on a secure portal to minimize risks. Finally, the reporting system will automatically confirm fields within the submitted reports and streamline report entry on the front-end, while limiting errors and delays in follow-up.

HHSC has transferred the Texas Department of State Health Services (DSHS) reporting functions and staff to the HHSC Office of Performance, and has modified all current forms to meet minimum requirements for reporting. Technological build-out began in October 2018 with an anticipated system launch in April 2019.

Recommendations

1. **The Legislature should continue to work with HHSC and stakeholders to identify and close any reporting loopholes post rule adoption.**

2. **The Legislature should continue to ensure HHSC has the ability to properly track abortion reporting requirements.**

[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List,* September 12, 2018.
[2] Information provided by the Office of the Attorney General via email on October, 16, 2018.
[3] Texas Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services*, September 12, 2018.

KIRK WATSON
STATE SENATOR
DISTRICT 14

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November 27, 2018

Dear Chairman Schwertner,

Senate Health and Human Services Interim Committee Charge 6B asked our committee to consider past and potential new legislative action to address maternal mortality and morbidity, including recommending ways to improve health outcomes for pregnant women.

The state has a clear role and responsibility to reduce maternal deaths in Texas.

Since 2016, the Maternal Mortality and Morbidity Task Force has twice recommended increasing access to health services post pregnancy as the top priority. This recommendation is responsive to significant and telling data that illustrate the potential to prevent such deaths in the future:

- the majority of deaths (in 2012) were more than 60 days postpartum
- the majority of deaths were substance use related (2012-2015)
- the majority of all maternal deaths within a year of the pregnancy were women enrolled in the Medicaid program at the time of delivery

In my opinion, extending full coverage from 60 to 365 days post-pregnancy would be the smartest investment for the state. However, there are other incremental options that would still benefit Texans such as extending the 60 day deadline by increments over the course of one or two biennia. As an alternative, services after 60 days post-pregnancy could be limited to behavioral health care.

I look forward to working with you, members of the committee and the full Senate to ensure the state budget makes smart investments in Texans that pay dividends in the next biennium and into the future.

Sincerely,

Kirk Watson

KONNI BURTON
STATE SENATOR • DISTRICT 10

November 28, 2018

Dear Chairman Schwertner,

Thank you for your leadership on this committee and the diligent and careful work presented in this report. Although I intend to sign the report, as I am in agreement with most of the recommendations presented, I would like to highlight some key issues of concern I have regarding a few of the recommendations.

I am first concerned with a recommendation under Interim Charge 1A that reads, "The Legislature should continue to support mental health programs like Mental Health First Aid and the Mental Health Professional Loan Repayment Program."

I cannot support the creation, expansion, or existence of any type of educational loan repayment program. Allow me to explain why.

While encouraging the expansion of the mental health treatment workforce is a laudable goal, loan repayment programs are not the best way to pursue this aim.

First, loan repayment programs subsidize one career path, favoring it over others. Rather than allowing prospective job candidates to weigh options based on their own interests, goals and, market forces such as salary, benefits, and other considerations, a loan repayment program distorts the job market and incentivizes market entrants to make decisions based on government's action in the market. I am philosophically opposed to this practice because it is contrary to our free enterprise system, is not the role of government, and is central planning at its core.

Secondly, loan repayment programs insulate a consumer of education (the student) from the full cost of his or her choices (tuition). This not only gives educational institutions no incentive to reduce tuition costs, it virtually guarantees that tuition will rise to account for the subsidy.

I would instead favor the use of state funds to increase wages for mental health personnel working in the state or local public sector of this field, as this is a market signal indicating an increase in demand for this profession, rather than a distortionary tuition subsidy.

I am secondly concerned with the last recommendation under Interim Charge 2C that reads, "HHSC, DFPS, and the Legislature should examine how former foster youth are notified about the need to re-enroll in Medicaid annually." While I am certainly in favor of helping those who cannot help themselves, I would caution the body not to pursue policies that either directly or indirectly foster dependence on the state's safety net healthcare program. Given that Medicaid is such a large and growing fixture of the state budget, we should be looking for ways to encourage individuals to take responsibility for their own health insurance instead of encouraging dependence on this entitlement.

Thank you again for your work on this report and for providing me the opportunity to voice my concerns.

In Liberty,

Konni Burton

Senator Konni Burton