TEXAS SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

INTERIM REPORT
TO THE
84TH LEGISLATURE

December 2014

THE SENATE OF TEXAS
COMMITTEE ON HEALTH AND HUMAN SERVICES

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

E-MAIL:
Charles.schwertner@senate.state.tx.us

SENATOR CHARLES SCHWERTNER
Chair
SENATOR BOB DEUELL
Vice-Chair
SENATOR JOAN HUFFMAN
SENATOR JANE NELSON
SENATOR ROBERT NICHOLS
SENATOR LARRY TAYLOR
SENATOR CARLOS URESTI
SENATOR ROYCE WEST
SENATOR JUDITH ZAFFIRINI

December 1, 2014

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

Dear Governor Dewhurst:

The Senate Committee on Health and Human Services submits this report in response to the interim charges you assigned 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 reducing child fatalities in our Child Protective Services system, improving our behavioral health system, delivering health care services to Texas' vulnerable populations in a fiscally responsible manner, and combating prescription drug abuse. 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 Bob Deuell
Vice-Chair

Senator Joan Huffman

Senator Jane Nelson

Senator Robert Nichols

Senator Larry Taylor

Senator Carlos Uresti

Senator Royce West

Senator Judith Zaffirini

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Interim Charge #1- Child Protective Services

Interim Charge Language: *Review the Department of Family and Protective Services' efforts to reduce child fatalities. Review the process by which the Department of Family and Protective Services collects and uses data to evaluate agency performance and improve outcomes for children in the Child Protective Services system. Make recommendations to ensure the process effectively uses data to strategically improve caseworker performance, and identify and improve upon deficiencies within the system and improve overall outcomes for children and reduce child fatalities.*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on February 20, 2014 to discuss Interim Charge #1 related to child fatalities and effective use of data within the Child Protective Services (CPS) division of the Department of Family and Protective Services (DFPS). Representatives from the Health and Human Services Commission (HHSC) and DFPS provided invited testimony. Twenty-five individuals provided public testimony before the Committee, fifteen of whom also provided written testimony.[1]

Introduction and Background

The CPS division within DFPS has undergone significant changes over the past decade, due to statutory changes as well as internally-driven initiatives and policies. This has distracted from their core mission of ensuring the safety of children and has prevented the agency from establishing a solid foundation based on sound management structure and a strategic vision. The Sunset Advisory Commission's review of the agency, released in May 2014, and The Stephen Group's external operational review conducted in April 2014 recognized this dilemma in their respective reports.[2] Sunset's report summarized the problem by stating, "What DFPS sorely needs is a timeout to breathe and a chance to regroup after being in near constant transition for so long. The agency needs to roll up its sleeves and get down to the mundane business of effective management, long lost in a culture of addressing every problem that pops up with a new policy or initiative."[3]

In August 2014, the Sunset Advisory Commission adopted numerous recommendations to improve the management structure and culture at the agency, address issues that contribute to high caseworker turnover rates, better utilize data to assess risk to children during investigations, and elevate prevention and early intervention programs within the agency.[4]

Rather than add to the list of tasks and recommendations the agency must implement, the purpose of this report is to give a brief overview of the many initiatives that are currently taking place to transform the CPS system, and to emphasize and expand on recommendations made by the Sunset Advisory Commission and the Stephen Group that could have a profound impact on reducing child fatalities and improving the use of data by the agency.

Current Reviews and Initiatives Impacting CPS

In addition to this Committee's interim study, several initiatives are taking place concurrently to evaluate and improve various aspects of CPS.

Sunset Advisory Commission Review

The Sunset Advisory Commission Staff Report on DFPS, issued in May 2014, devoted several chapters to the agency's CPS division and identified many recommendations to improve outcomes in the CPS system. These recommendations focused on improving retention of CPS caseworkers through improvement of internal management practices; developing an effective, strategic approach to managing its operations, including planning, policymaking, and performance management; and expanding and improving metrics used in investigations, among others.[5] On August 13, 2014, the Sunset Advisory Commission adopted all of Sunset's recommendations, in addition to several member modifications that will:

- Statutorily require CPS to develop an annual business plan that will be reported to the Legislature;
- Require DFPS to implement appropriate changes identified in the Stephen Group Operational Review with an immediate focus on changes related to retaining caseworkers, process changes that will improve the computerized casework system and facilitate structured decision making, and streamlining policy to refocus team members on spending time with children and families;
- Require DFPS to report CPS performance measures to the Sunset Advisory Commission every six months, including staff turnover rates and recidivism into the CPS system;
- Direct CPS to expand its connection to the faith-based community, beyond adoption and permanency, to fill gaps in contracted services; and
- Elevate the Prevention and Early Intervention programs within CPS to a separate division that reports directly to the Commissioner.[6]

The Sunset report including decision documents and the full list of adopted recommendations can be found at:
https://www.sunset.texas.gov/public/uploads/files/reports/DFPS%20Decision%20Material.pdf.

The Stephen Group Review

The Stephen Group was retained by HHSC and DFPS in February 2014 to conduct a broad operational review of the Child Protective Services (CPS) division within DFPS. The operational review's objective was to conduct a "top to bottom" assessment of CPS followed by recommendations and an implementation plan. The scope of the review included CPS organization, work flow, allocation of staff, decision making, policy development, continuous quality improvement, budgeting, training, hiring, contracting, and finance. The operational review's goal is to design a transformational project that will better enable CPS to promote child safety, well-being, and permanency.[7] The Stephen Group's assessment, issued in April 2014, and their recommendations, issued in June 2014, echoed and reinforced many of the recommendations Sunset made in their May report.[8] DFPS is in the process of implementing an agency-wide Transformation Plan based largely on the recommendations of Sunset and the Stephen Group.[9]

DFPS Child Safety Plan for Children in Foster Care

Overall, child fatalities in Texas and in the CPS system as a whole have declined from previous years. However, the number of fatalities among children in conservatorship of the state experienced a sharp increase from FY 12 when there were two such fatalities, to FY 13 when there were eight.[10] In response to the disturbing trend seen in FY 13 and requests from legislators to improve safety of children in the state's care, DFPS issued a *Safety Plan for Children in Foster Care* in October 2013.[11] The Safety Plan included 31 specific recommendations that focus on increasing unannounced visits, educating and equipping caseworkers to better protect children with Primary Medical Needs (PMN), increasing outreach to caregivers on how to ensure the safety of children in their care, facilitating safety forums with agency staff and providers to develop best practices in child safety, and increasing and improving training on child safety for caseworkers. Twenty-eight of the 31 recommendations have been completed or are ongoing.[12]

IMPACT Modernization Plan

As part of the broader Transformation Plan that DFPS is undertaking to overhaul its operations, the agency has embarked on a four-year project to modernize the Information Management Protecting Adults and Children in Texas (IMPACT), the computerized casework system all DFPS programs use to record case intakes and document investigations and all case actions.[13] The 83rd Legislature invested $28 million for the first two years of this four-year modernization project.[14]

The current IMPACT system, which is 17 years old, has historically been used as a dumping ground for case information and has become an administrative afterthought for caseworkers, rather than a tool to better protect children and serve families. As envisioned, the modernized IMPACT system will be centered around a web application that will enable DFPS and external partners such as the judiciary, law enforcement, Child Advocacy Centers, Child-Placing Agencies, and other stakeholders to efficiently and effectively enter, process, and analyze case information.[15] A modernized IMPACT system will more efficiently and effectively collect and utilize data to improve caseworker and investigator decisions and, ultimately, improve outcomes for children. In Fiscal Year 2014, DFPS established a detailed project management plan to guide the modernization project, selected technology architecture and purchased the necessary hardware and software for the project, automated a deadline reminder system for caseworkers, developed a fatality information tracking system, and created access to IMPACT for Court Appointed Special Advocates. More extensive changes are planned for future years to further enhance the system and complete the IMPACT modernization project.

Conclusion

CPS has been entrusted with a sacred duty- to protect children, our state's most precious resource. The importance of this mission must not be buried under an inordinate amount of policies, programs, procedures and paperwork. CPS' focus should be squarely on creating a functioning management and organizational structure, reinventing the culture of the agency, and growing and supporting the caseworkers who are on the frontlines every day. The Committee fully supports and endorses the recommendations adopted by the Sunset Advisory Commission

at their August 13 decision meeting, which aim to improve child safety and caseworker retention, and strengthen the overall management structure of the agency.

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[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List,* February 20, 2014: http://www.legis.state.tx.us/tlodocs/83R/witlistmtg/pdf/C6102014081509001.
[2] The Stephen Group, *DFPS CPS Operational Review, Phase 1: Recommendations*, June 2014.
[3] Sunset Advisory Commission, *Staff Report: Department of Family and Protective Services*, May 2014.
[4] Sunset Advisory Commission, *Staff Report with Commission Decisions: Department of Family and Protective Services*, August 2014.
[5] *Supra* note 3.
[6] *Supra* note 4.
[7] The Stephen Group, *DFPS CPS Operational Review, Phase 1: Assessment/Findings,* April 28, 2014.
[8] *Id* and *Supra*, note 2.
[9] Information about CPS Transformation may be accessed at: http://www.dfps.state.tx.us/Child_Protection/About_Child_Protective_Services/transformation.asp
[10] *Supra* note 4.
[11] Department of Family and Protective Services, Safety Plan for Children in Foster Care, October 24, 2013. Available at: http://www.dfps.state.tx.us/Child_Protection/Child_Safety/documents/DFPS_Safety_Plan_for_Children_in_Foster_Care.pdf
[12] Department of Family and Protective Service, Child Safety Action Plan. Available at: http://www.dfps.state.tx.us/Child_Protection/Child_Safety/documents/Child_Safety_Action_Plan.pdf
[13] IMPACT Modernization as of August 1, 2014. Available at: https://www.dfps.state.tx.us/PCS/impact_modernization.asp
[14] Senate Bill 1, Article II, Department of Family and Protective Services, 83rd Regular Session (Williams/Pitts).
[15] *Supra* note 13.

Interim Charge #2- Mental Health and Substance Abuse

Interim Charge Language: *Monitor the implementation of programs that were created or expanded by the 83rd Legislature to improve mental health and substance abuse services and assess these efforts' contribution to improved outcomes such as reduced recidivism in state hospitals, diversion from emergency rooms and county jails, and access to permanent supportive housing. Identify and address gaps in the current mental health and substance abuse system and make recommendations to better coordinate services across agencies and programs.*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on August 15, 2014 to discuss Interim Charge #2 related to mental health and substance abuse. Representatives from the Department of State Health Services (DSHS), the Health and Human Services Commission (HHSC), the Sunset Advisory Commission, and the Meadows Institute for Mental Health Policy in Texas provided invited testimony. Eight individuals provided public testimony, two of whom also provided written testimony. Four additional individuals submitted testimony in written form only.[1]

Introduction and Background

All Texans have been impacted by mental illness or substance abuse to some degree-- through a personal experience, as a taxpayer who supports the county jails, state psychiatric hospitals, and hospital Emergency Rooms (ERs) that often provide treatment to those dealing with behavioral health issues, or simply as a witness to the preventable tragedies that have become all too common in recent years. Failure to recognize the importance of behavioral health prevention and treatment results in lost productivity, lower quality of life for those who suffer with behavioral health conditions and their families, and unnecessary and costly expenditures in our ERs, state hospitals, and criminal justice system.

The 83rd Legislature recognized the importance of making an investment in behavioral health and dedicated an unprecedented level of funding to substance abuse and mental health awareness, prevention, and treatment, increasing funding for these purposes by more than $360 million, or 16%, over the previous biennium.[2] In addition to the efforts of the Legislature, providers across the state are implementing projects related to behavioral health through the 1115 Medicaid Transformation Waiver. Over the first two years of the waiver, 390 Delivery System Reform Incentive Payment (DSRIP) projects related to behavioral health are eligible to earn $937 million.[3]

In addition to these investments, awareness of behavioral health issues and interest in improving public policy related to behavioral health have also increased. In April 2014, the Meadows Mental Health Policy Institute for Texas was launched as a non-partisan, data-based, privately funded institute dedicated solely to developing mental health policies for Texas.[4] The first endeavor of its kind in the country, the Meadows Institute has already increased awareness with widely attended and viewed events across the state, and promising policy research underway on many important mental health topics.

All of these factors--the commitment of the Legislature, the opportunities presented by the 1115 Waiver, and the expertise offered by the Meadows Institute--have culminated to position the improvement of behavioral health as an important issue that can and should be addressed. Despite the progress that has been made through this increased funding and heightened awareness and interest, there is still significant work to do to ensure a cohesive and effective behavioral health system.

First and foremost, the behavioral health system in Texas must be just that--a *system*, rather than a smattering of disconnected programs and initiatives buried within an overloaded public health agency responsible for responding to food borne illnesses, disease outbreaks, and natural disasters. There must be greater coordination and collaboration across programs and agencies that relate to mental health or substance abuse, leadership to facilitate such coordination, and structural changes to elevate behavioral health within the broader health and human services enterprise. Additionally, the behavioral health landscape in Texas must be carefully evaluated in light of the investments made last session to determine where gaps remain and what can be improved upon.

Legislative Investment

The 83rd Legislature's investment of $6.6 billion in mental health and substance abuse over the Fiscal Year 2014-15 biennium, a $300 million increase over Fiscal Year 2012-13, was targeted at many different aspects of behavioral health.[5] In order to identify aspects of the state's behavioral health system that may warrant additional attention or resources, it is important to first understand how the additional funding was invested and its impact on services. The items listed below are not intended to be a full accounting of all behavioral health initiatives funded by the 83rd Legislature, but rather to highlight the aspects of behavioral health the Legislature's investment have sought to address.

Prevention and Education

Prevention, early identification, and education are essential elements of any effective behavioral health system. The 83rd Legislature funded initiatives to increase public awareness of mental illness and encourage early identification of behavioral health issues among children in order to prevent more costly and detrimental manifestations of mental illness later in life.

Public Awareness Campaign: $1.6 million was appropriated to create a public awareness campaign that seeks to motivate and empower parents and other adults in the sphere of influence of teens and young adults on how to identify signs of trouble and where to get help, and to motivate those ages 14-24 to seek help if they need it. The campaign was launched in June 2014 and 16 "community conversations" have been held across the state to promote the campaign. DSHS has partnered with the 2-1-1 system to promote the campaign, and 2-1-1 has experienced an increase of about 100 mental health-related calls per day, a 65% increase since the start of the campaign.[6]

Mental Health First Aid: $5 million was appropriated to train educators in Mental Health First Aid, which teaches the potential risk factors and warning signs of mental illness and how to assess a situation and develop and implement an appropriate intervention to help a student

experiencing a mental health crisis obtain appropriate professional care. In Fiscal Year 2014, 7,776 educators received Mental Health First Aid training.[7]

Ensuring Access to Services in Appropriate Settings

Ensuring that individuals with mental illness and substance abuse disorders receive treatment when they need it and in an appropriate clinical setting is key to preventing further decompensation and avoiding more costly and less appropriate stays in ERs and county jails. The 83rd Legislature invested in the following initiatives aimed at ensuring access to services in appropriate settings:

Reducing the Waiting List: $48 million was appropriated to eliminate the waiting lists for adult and children to receive community-based services. In February 2013, 5,321 adults and 194 children were on the waiting list. As of August 31, 2014, the waiting list had been reduced to 361 adults and 7 children.[8]

Underserved Individuals: $23 million was appropriated to provide the full array of necessary services to underserved individuals receiving community-based mental health services. As of August 2014, 1,694 individuals had been moved to a more appropriate level of care.[9]

Crisis Services: $25 million was appropriated to expand crisis services, including establishing 16 new residential crisis treatment centers, and expanding three existing centers.[10]

Jail Diversion: $10 million was appropriated to fund a jail diversion pilot program in Harris County, requiring local matching funds. The pilot program provides intensive in-jail, supportive housing, wrap-around, and transition services to individuals with a serious mental illness who have been booked into the Harris County Jail three or more times in the past two years. The program was launched on August 21, 2014 and 25 individuals were being served as of October 8, 2014.[11]

Preventing Relinquishment of Custody: $24 million was appropriated as state match to draw down federal funds for the statewide expansion of the 1915(c) Youth Empowerment Services (YES) waiver. The YES waiver provides intensive community-based mental health services to children ages 3 to18 who are at-risk of parental relinquishment due to a need for services to treat Serious Emotional Disturbance (SED). The waiver, which was previously only accessible in Travis, Tarrant, and Bexar counties, was expanded to Harris County in February 2014 and to Cameron, Hidalgo, and Willacy Counties in June 2014. Expansions to Williamson and McLennan counties, as well as to the NorthSTAR service area in north Texas, are planned for 2015. All future expansions must be approved by the Centers for Medicare and Medicaid Services (CMS). As of August 1, 2014, 387 clients were enrolled in the waiver. 456 clients have received services through the waiver since September 1, 2013.[12]

Substance Abuse Expansion: $15.6 million was appropriated to expand substance abuse treatment program capacity and to increase reimbursement rates of substance abuse providers to ensure an adequate provider network. This funding has allowed for an additional 1,183 clients to be served compared to the previous fiscal year, and has seemingly stopped the exodus of substance abuse providers from the system.[13]

Reducing Homelessness

Individuals dealing with mental illness are more likely to be homeless and are at much higher risk of becoming homeless than those without a behavioral health condition. Without reliable housing and related support services to maintain housing, these individuals are unable to focus on recovery, reintegrate into the community, and live a productive life. The 83rd Legislature invested significant funds into housing solutions for those with mental illness through several initiatives.

Supportive Housing: $12.1 million was appropriated to provide rental assistance and supportive housing through the Local Mental Health Authorities (LMHAs) for individuals who, despite ongoing treatment through an LMHA or NorthSTAR provider, are homeless or at significant risk of becoming homeless. Funding was anticipated to serve about 650 individuals, but LMHAs and NorthSTAR providers have been able to serve 1,785 individuals.[14]

Community Collaboratives: $25 million was appropriated to create community collaboratives of municipal government leaders, non-profit organizations, advocates, businesses, and consumers in the five largest counties in the state (Bexar, Dallas, Harris, Tarrant and Travis). These collaboratives, which were required to provide 1:1 private matching funds, are working to build on their strengths and community resources to address the problem of homelessness among individuals with a mental illness. Contracts have been executed in four of the five counties, with the fifth contract pending final processing as of late October 2014.[15]

Home and Community-Based Services: $7.9 million was appropriated to seek federal approval for a 1915(i) state plan amendment to provide Home and Community-Based Services (HCBS) to 106 adults with complex behavioral health needs who have had extended or repeated stays in a state hospital. An application for the state plan amendment has been submitted to CMS by DSHS and HHSC and CMS has until January 6, 2015 to approve, deny, or request more time to consider the proposal.[16]

Integration of care

In addition to making extraordinary investments in behavioral health, the 83rd Legislature sought to more fully integrate physical and behavioral health in the Medicaid program. Senate Bill 58 (Nelson, 83R) carved behavioral health services into Medicaid Managed Care, which will expand the provider network, provide more integrated care for this population, and ensure cost certainty for the state.[17]

1115 Transformation Waiver

The 1115 Transformation Waiver, a state, local and federal partnership, has presented a unique opportunity to improve Texas' behavioral health system, with 396 approved DSRIP projects related to behavioral health, almost a third of total approved projects. Collectively, these projects are eligible to earn over $2 billion over the five year life of the waiver and are will serve an estimated 241.083 individuals in the final year of the waiver.[18] These 396 DSRIP projects include:

- 90 interventions to prevent the unnecessary use of services in the criminal justice system, inpatient psychiatric hospitals, or hospital Emergency Rooms;
- 58 projects to enhance behavioral health service availability through extended hours, additional clinical locations, transportation assistance, and mobile clinics;
- 49 projects to develop behavioral health crisis stabilization services;
- 66 projects to integrate primary and behavioral health services;
- 21 projects to expand or support the mental health workforce by collectively recruiting 555 mental health professionals;
- 39 projects to utilize telemedicine or technology assisted services to support or deliver behavioral health care services.[19]

Innovative DSRIP Projects

One benefit of the 1115 waiver DSRIP project design is that it allowed local collaboratives, through the Regional Health Partnerships, to identify the most pressing behavioral health needs in their communities and design innovative projects to address those needs. Some examples of this locally-driven innovation include:

- A collaboration between the LMHA, local Federally Qualified Health Center (FQHC), and community hospital to fully integrate primary and behavioral health care using a "More than co-location" model;
- Directly referring psychiatric patients being discharged from an ER or crisis stabilization unit to an Intensive Outpatient Treatment program to prevent unnecessary inpatient stays;
- Integration of behavioral health into the outpatient obstetrics setting to provide increased access to mental health services for the treatment of postpartum depression;
- Development of a mobile clinic to provide comprehensive behavioral health services to outlying areas of rural counties; and
- Creating mental health courts in counties without these resources.[20]

The Future of the 1115 Waiver

The 1115 waiver expires on September 30, 2016, and Texas must submit a request for an extension or renewal of the waiver by September 30, 2015. HHSC is currently in the process of drafting the renewal plan and will hold stakeholder meetings regarding the agency's plan for renewal during the summer of 2015.[21]

Performing providers of DSRIP projects are required to report on their progress in serving Medicaid and low-income uninsured patients every six months. Baseline data were submitted in October 2014, which will allow the future measurement of quantifiable patient metrics, beyond the number of individuals served. Data showing whether patient metrics actually *improved* will not be available until fall 2015, after the conclusion of the legislative session and the deadline for the state to apply for renewal or extension of the waiver.[22] This timeline will prevent the Legislature and CMS from having outcome improvement data prior to deciding whether to renew the waiver. The agency and participating providers should work to provide as much data on outcomes as possible prior to the renewal deadline. If sufficient data is not available, the agency may need to consider applying for a one year extension of the waiver rather than a renewal to allow time for quantifiable outcome data to be collected in order to determine which should projects be continued.

Conclusion

The state of Texas-- including the Legislature, advocates, providers, and consumers-- has made clear their commitment to creating a better, more accountable behavioral health system that treats people when they need help in an appropriate setting. The growth of investment and interest in behavioral health that has occurred since 2013 has put Texas on the right path. However, there are additional steps that should be taken to ensure a proactive, cohesive, and collaborative behavioral health system in Texas.

Recommendations

The recommendations of this committee span the full continuum of care and address many different aspects of behavioral health.

Structural Reform:

1. **Mental health and substance abuse programs should be elevated from their current status as a division within the Department of State Health Services to a more highly visible position within the Health and Human Services Enterprise that will ensure adequate leadership and accountability.**

Early Intervention and Identification:

2. **Expand Mental Health First Aid to include additional school personnel.**
   In addition to educators, school personnel such as counselors, school nurses, teacher's aides, school bus drivers, principals, assistant principals, and school resource officers have frequent contact with students and should have the opportunity to receive Mental Health First Aid training.

Mental Health Workforce:

3. **Create a loan repayment program for mental health professionals.**
   Texas has 333 Mental Health Professional Shortage Areas in the state, which are defined as areas in which the population to provider ratio is at least 30,000 to one. This has resulted in less than half (46.75%) of the need for professional mental health services being met in the state.[23] In an effort to begin addressing our mental health workforce shortage, Texas should create a Mental Health Professionals Loan Repayment Program for psychiatrists, psychologists, advanced practice psychiatric nurses, licensed professional counselors, and licensed clinical social workers who provide direct care in Mental Health Professional Shortage Areas. Similar to the existing Physician Loan Repayment Program, eligible candidates should hold the appropriate degree and licensure, agree to serve five years in a federally designated Mental Health Professional Shortage Area, and provide care to Medicaid and CHIP clients. The number of total slots

in the program should be determined by the Legislature through the appropriations process, but no single profession should receive more than 30% of the available slots.

4. **Promote the use of Certified Peer Specialists.**
   Certified Peer Specialists are individuals in recovery from mental illness or substance abuse who have received training to effectively use their recovery story to help other individuals suffering from mental illness or substance abuse. The nationally recognized curriculum for Certified Peer Specialists involves 35 hours of training followed by a written examination and the completion of 20 hours of continuing education every two years.[24] Although Certified Peer Specialists cannot and should not replace trained mental health professionals such as psychiatrists and professional counselors, they can enhance treatment and support services for individuals in recovery from a mental illness or chemical dependence. While many LMHAs routinely utilize Certified Peer Specialists, the state should explore other opportunities to utilize the peer workforce, including determining the cost effectiveness of certifying Certified Peer Specialists as a Medicaid provider type, as required by Senate Bill 58 (Nelson, 83R).

Diversion from Higher Cost Settings:

5. **Ensure crisis stabilization services are available in all areas of the state to avoid more costly and restrictive treatment settings such as Emergency Rooms and county jails.**
   Crisis stabilization units are cost-effective and provide more appropriate care for individuals than ERs and jails. They also help avoid unnecessary stays in inpatient settings such as state hospitals. There are currently 57 counties in Texas without crisis stabilization beds or any other facility-based inpatient option.[25] Texas should seek to address this lack of crisis services in these areas of the state.

6. **Carefully evaluate the Harris County Jail Diversion Pilot Program to determine if expansion is warranted.**
   The Harris County Jail Diversion Pilot Program provides intensive in-jail, community, supportive housing and transition services to individuals with a serious mental illness who have been booked into the Harris County Jail three or more times in the past two years. The pilot project, which requires a local match, may be a promising model for other regions of the state with high rates of mentally ill individuals encountering the criminal justice system on a frequent basis. Although this is a four year pilot project and comprehensive outcomes data will not be available for some time, DSHS should begin collecting and evaluating outcome data as soon as possible to determine if reduced recidivism rates and cost savings are being realized, which may justify the expansion of this program to other areas of the state.

Collaboration:

7. **Encourage jails to allow Mobile Crisis Outreach Teams into their facilities.**

All LMHAs are equipped with Mobile Crisis Outreach Teams (MCOTs) of medical and mental health professionals that respond on-site immediately when a psychiatric crisis occurs. Some county jails have developed relationships with their LMHAs and utilize the services of their MCOTs to prevent suicides and other serious cases in which an inmate suffering from mental illness is in danger of severely decompensating. All jails in the state should develop such relationships and should rely on MCOTs in their communities.

8. **Create a centralized online source of information about behavioral health prevention, treatment, and recovery for patients, families, providers and advocates.** There are multiple websites and other sources of information available to behavioral health stakeholders, and little awareness about crucial information such as where to find services, how to tell if a loved one may be dealing with a mental health or substance abuse issue, and where to obtain Mental Health First Aid training. HHSC should create and promote an interactive online portal, including mobile applications, to serve this function.

Integration:

9. **Encourage integration of substance abuse and mental health services by providing grants for the co-location of providers.**
DSHS should establish a grant program to allow LMHAs to provide substance abuse services on site and for substance abuse provider sites to provide behavioral health services on site. Grant funding should be awarded on a competitive basis and preference should be given to LMHAs and substance abuse providers located in areas with the greatest need for services. Priority should also be given to LMHA clinical sites that have the highest volume of referrals to substance abuse services and to substance abuse providers with the highest volume of referrals to LMHAs and other mental health providers.

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[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List,* August 15, 2014: http://www.legis.state.tx.us/tlodocs/83R/witlistmtg/pdf/C6102014081509001.PDF.
[2] Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, August 15, 2014, p. 6. Full presentation found at: https://www.dshs.state.tx.us/legislative/default.shtm
[3] Health and Human Services Commission, *Testimony before the House Appropriations Article II Subcommittee*, June 16, 2014, p. 7.
[4] Business Wire, *The Meadows Mental Health Policy Institute Launches with 'Texas State of Mind' Conference,* April 16, 2014.
[5] *Supra* note 2.
[6] Department of State Health Services, *Major Mental Health and Substance Abuse Initiatives Update*, September 2014.
[7] Department of State Health Services, Information received via email, September 24, 2014.

[8] Department of State Health Services, *Major Mental Health and Substance Abuse Initiatives Update*, October 22, 2014.
[9] Information provided by Department of State Health Services via email, October 23, 2014.
[10] *Id.*
[11] Harris County Office of Legislative Relations, *Implementation of SB 1185 Harris County Jail Diversion Pilot Project: Update Provided to Senate Committee on Criminal Justice*, September 22, 2014.
[12] *Supra* note 6.
[13] *Supra* note 2, p. 12.
[14] *Supra* note 8.
[15] *Id.*
[16] Information provided by from Department of State Health Services via email, October 22, 2014.
[17] Senate Bill 58, 83rd Regular Session, 2013 (Nelson/Zerwas).
[18] Texas Institute for Excellence in Mental Health, *Texas 1115 Medicaid Demonstration Waiver: Review of 4-Year Behavioral Health Projects*, November 1, 2014.
[19] *Supra* note 3 and *Supra* note 18.
[20] Health and Human Services Commission, *Approved Behavioral Health DSRIP Projects*, provided March 2014.

[21] Health and Human Services Commission, *Next Steps for DSRIP and the Waiver*, pp. 3-5, Presented at DSRIP Statewide Learning Collaborative Summit, September 10, 2014.
[22] *Id.*
[23] Kaiser Family Foundation, *Mental Health Professional Shortage Areas*, April 28, 2014.
[24] ViaHope Texas Mental Health Resource, Peer Specialist Training and Certification. Available at: http://www.viahope.org/programs/training-certification.
[25] Department of State Health Services, *Testimony before a Joint Hearing of the Legislative Budget Board and the Governor's Office of Budget, Policy and Planning*, September 25, 2014.

Interim Charge #3- Women's Health

Interim Charge Language: *Build on previous legislative achievements in women's healthcare by examining women's access to preventative health care, pregnancy services, and post-partum care, and exploring ways to expand access and improve quality, particularly in rural and underserved areas of the state. Monitor the implementation of women's health programs in Texas. Assess these programs' impact on outcomes such as improving access to preventative services, reducing unplanned pregnancies, and achieving cost savings. Recommend ways to better coordinate the various programs in a manner that increases the number of women served, ensures adequate provider capacity statewide, and maximizes efficiencies to the state.*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on February 20, 2014 to discuss Interim Charge # 3 related to women's health. Representatives from the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) provided invited testimony. Forty five individuals provided oral testimony, twenty five of whom also submitted written testimony. An additional twelve individuals provided testimony in written form only.[1]

Introduction and Background

Texas operates programs that provide a wide range of women's health services, including preventative screenings, family planning services, prenatal and postpartum care, and cancer treatments. The 83rd Legislature made a significant investment in women's health programs, appropriating more than $240 million over the FY 14-15 biennium for the Texas Women's Health Program (TWHP), Expanded Primary Health Care (EPHC) program, DSHS Family Planning program, and Breast and Cervical Cancer Screening (BCCS).[2] In addition to these programs, Texas provides additional healthcare services to women through Medicaid, CHIP Perinatal, and the Title V Prenatal program.[3]

The Legislature has demonstrated a commitment to ensuring access to healthcare services for low-income women, but the state's financial investment is just the first step in ensuring that the state has a robust, cohesive women's health system. Moving forward, the state should focus on three areas to ensure continuity of care and expanded access:

- Outreach and education to ensure women and providers are aware of the availability of services;
- Streamlining programs to make them easier for clients and providers to navigate; and
- Expanding access to the most effective forms of contraceptives.

Outreach

HHSC conducted an extensive outreach campaign in October 2013 to increase awareness of and participation in TWHP, which serves over 115,000 women annually and is the largest women's health program in Texas.[4] As part of these outreach efforts, the agency developed new print materials about the program, supplied application holders and posters to all HHSC benefit offices for display, and provided over 235,000 outreach materials such as brochures, information cards, and posters to providers and community organizations. HHSC also provided the Office of the

Attorney General Child Support Division with TWHP materials for display in all local field offices.[5]

In addition to these activities to increase awareness of TWHP specifically, HHSC hired a contractor to develop a new comprehensive women's health website which will act as a hub of information on all of the programs available to women, screen for eligibility, and direct women to existing program websites. The new website was publicly launched on November 12, 2014.[6]

Streamlining Programs

The plethora of women's health programs in Texas, each with different eligibility criteria and enrollment processes, can be difficult for women to navigate and is administratively burdensome for providers who participate in multiple programs. A summary of the programs in Texas that provide healthcare to women can be found on pages 20-21. HHSC and DSHS have taken steps to address these concerns, as described below.

Title X Reporting

Provider contracts with the federal government for Title X family planning grants require grant recipients to report the number of all family planning patients seen in the Title X clinic, regardless of the funding source. The original contract language governing the Expanded Primary Health Care (EPHC) program prohibited contractors from counting EPHC clients in their Title X numbers.[7] This resulted in providers who participated in both Title X and EPHC being unable to comply with the competing requirements of these programs, and led to some large health clinics choosing not to apply for participation in the EPHC program.

As of September 1, 2014, rules governing the EPHC program were changed to allow contractors to report their numbers to Title X.[8] Although this will likely inflate the number of women the Title X program can claim were served using Title X dollars, it removed an administrative burden that created a disincentive for providers to participate in both the Family Planning and EPHC programs and therefore allows more women to be served.

Class D Pharmacy Waiver

Until recently, providers in the EPHC program were required to have a Class D Pharmacy on-site.[9] This was intended to ensure that women would have on-site access to prescription contraceptives, but had the unintended consequence of preventing many qualified providers from participating. In May 2014, DSHS created a waiver process for the Class D Pharmacy requirement. The waiver is available to contractors in areas where there is a reliable network of pharmacies in the community to ensure access to prescription birth control.[10]

Increasing Access to Effective Methods

Long-Acting Reversible Contraceptives (LARCs), such as intrauterine devices and contraceptive implants, have been shown to be the most effective form of contraception, and increased use of LARCs could potentially reduce unintended pregnancies.[11] [12] However, in Fiscal Year 2013, only 6.5% of TWHP clients and 9% of DSHS Family Planning clients received LARCs, and projections show that 15% of EPHC clients received LARCs in Fiscal Year 2014.[13]

Adding LARC as a Pharmacy Benefit

Prior to August 1, 2014, the only option for doctors wishing to provide LARCs to patients was to buy the products and bill Medicaid once they were implanted or inserted. This buy-and-bill model creates a disincentive for many small providers to use LARCs, since the cost of a single LARC ranges from $600-800 and they may not have the ability to purchase these products up-front.[14] Additionally, reimbursement rates for LARCs under the buy-and-bill system are updated every two years, while the cost of these products is typically increased by manufacturers at least once a year, making it impossible for reimbursement rates to keep up with actual costs of the product.[15]

As of August 1, two of the four LARCs available through the Texas Medicaid program have been added to the Medicaid and TWHP drug formularies.[16] This will give providers the option of prescribing a LARC to a patient and having a pharmacy ship the device to the doctor overnight. The manufacturer of the two products added to the formulary has agreed to buy back prescribed LARCs that are not actually used by the provider. As a pharmacy benefit, rates for these two LARCs will be updated any time the manufacturer's price is increased.[17]

Conclusion

The importance of ensuring that women have access to preventative healthcare including family planning services cannot be overstated. Healthy women form the foundation for strong, healthy Texas families. Although the Legislature has committed significant funding to support women's health programs, and our state agencies have taken steps to streamline these programs, there is still work to do to ensure a seamless system of care that is easy for women and providers to navigate.

Recommendations

1. **Consolidate women's health programs at one state agency.**
   The state's three major women's health programs, TWHP, EPHC and DSHS Family Planning, should all be housed at HHSC, and should be consolidated in a manner that ensures continuity of care and does not reduce access to services. Administrative elements of these programs, such as client eligibility determination, provider education, program accountability, and client outreach, should be streamlined as much as possible to make navigation of women's health programs easier for women and providers.

2. **Reduce gaps in family planning coverage**
   After a woman who is Medicaid-eligible delivers her child, she may only receive postpartum services, including contraception, for 60 days.[18] In the Perinatal Children's Health Insurance Program (CHIP), a woman receives two postpartum visits, which typically do not include contraceptive coverage.[19] Lags in coverage present the opportunity for unintended pregnancies to occur in the period after delivery of a child. This also presents an issue of not sufficiently spacing births, which can present health problems for the mother and child.[20] HHSC should determine the how to ensure eligible women are able to enroll in women's health programs prior to losing Medicaid or CHIP Perinatal eligibility.

3. **Add-on payment for LARCs**

Currently, when a woman on Medicaid gives birth and would like to begin the use of contraceptives prior to being discharged from the healthcare facility in which she delivered her child, there is no incentive for facilities to offer LARCs as a contraceptive option because the cost of purchasing LARCs is not covered in the bundled Diagnosis-Related Group (DRG) payment for labor and delivery and is not separately reimbursed.[21] Additionally, providers who participate in the state's women's health programs that operate on a fee-for-service basis, such as Family Planning and TWHP, are reimbursed per patient encounter, which does not cover the high cost of purchasing LARCs. Six states have instituted or plan to institute an add-on post-partum LARC payment outside of the global labor and delivery payment and are anticipating savings to their Medicaid programs and better birth outcomes.[22] HHSC should determine how to best ensure that reimbursement for LARCs incentivizes providers and healthcare facilities to offer this method of contraceptive, perhaps through add-on payments in addition to encounter and DRG payments. In doing so, the agency must carefully consider the managed care environment in which Texas Medicaid for pregnant women is operated.

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[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List,* February 20, 2014: http://www.legis.state.tx.us/tlodocs/83R/witlistmtg/pdf/C6102014081509001.

[2] Health and Human Services Commission and Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, February 20, 2014, p 11. Full presentation found at: http://www.hhsc.state.tx.us/news/presentations/2014/022014-womens-health.pdf.

[3] *Supra* note 2, p 38-39.

[4] *Id.*

[5] Information received from Health and Human Services Commission, via in-person meeting, May 1, 2014.

[6] Ross Communications Proposal

[7] Department of State Health Services, *Expanded Primary Health Care Program Statement of Work,* Fiscal Year 2014.

[8] Department of State Health Services letter to Expanded Primary Health Care Program Contractors, September 2, 2014.

[9] Department of State Health Services, *Expanded Primary Health Care Program FY 2014 Policy Manual*, , Section 2, Page 9.

[10] Department of State Health Services, *Expanded Primary Health Care Program Fiscal Year 2014 Policy Manual*, Section 2, Page 9 revision, May 2014.

[11] Winner, Brooke, et al., *Effectiveness of Long-Acting Reversible Contraception*, The New England Journal of Medicine, May 24, 2012, 366: p 1998-2007.

[12] Blumenthal,P.D., Voedisch, A., Gemzell-Danielsson, K., *Strategies to Reduce Unintended Pregnancies: Increasing Use of Long-Acting Reversible Contraception*, Human Reproduction Update, 2001, 17(1): p 121-137.

[13] Information provided by Health and Human Services Commission via email, October 28, 2014.

[14] Information provided by Health and Human Services via email, September 12, 2014.

[15] *Id.*

[16] *Id.*

[17] *Id.*

[18] *Id*.

[19] *Id*

[20] Norton, M., *New Evidence on Birth Spacing: Promising Findings for Improving Newborn, Infant, Child, and Maternal Health*, International Journal of Obstetrics and Gynecology, April 2005, Vol. 89, Supplement 1, p S1-S6.
[21] Information received from Health and Human Services Commission via conference call, September 5, 2014. Conference Call with HHSC Program staff 9/5/14
[22] Governing, *States Making Long-Term Contraception More Accessible*, September 2, 2014.

HHS Women's Health Programs

Texas Women's Health Program	Family Planning Program (FP)	Expanded Primary Health Care Program	Title V Prenatal	Medicaid – Women's Services	CHIP Perinatal	Breast and Cervical Cancer Screening	Medicaid for Breast and Cervical Cancer
Clients: ~117,000 (average monthly) women enrolled in FY13	***Clients:*** ~49,000 women served in FY13	***Clients:*** ~170,000 women served annually	***Clients:*** ~14,000 women served in FY13	***Clients:*** ~533,000 (average monthly) women enrolled in FY13	***Clients:*** ~37,000 (average monthly) women enrolled in FY13	***Clients:*** ~43,000 women served in FY13	***Clients:*** ~4,700 (average monthly) women enrolled in FY13
Eligibility: 185% FPL, Women Age 18-44 seeking family planning, US Citizens or eligible immigrants	***Eligibility:*** 250% FPL, Women of childbearing age who have not been sterilized and men who have not been sterilized, Texas resident.	***Eligibility:*** 200% FPL, Women Age over age 18, Texas Residents	***Eligibility:*** 185% FPL. women of child bearing age. Texas resident	***Eligibility:*** Medicaid-income eligible (varies by program), US Citizens or eligible immigrants, Texas residents (includes TANF, both child and adult, STAR Health, pregnant, and federal mandate clients)*	***Eligibility:*** 200% FPL, US Citizens or eligible immigrants, Texas residents, currently pregnant	***Eligibility:*** 200% FPL, women age 21-64, Texas resident	***Eligibility:*** 200% FPL, women ages 64 or younger, US Citizens or eligible immigrants, Texas residents, diagnosed and in need of treatment for either breast or cervical cancer
Annual Funding: $36 million General Revenue	***Annual Funding:*** $21.6 million All Funds ($18.8M General Revenue, $2.8M Federal/Other)	***Annual Funding:*** $50 million General Revenue	***Annual Funding:*** GR- $1.2M Fed (Title V) $291K	***Annual Costs:*** $3.7 billion All Funds ($1.5 billion General Revenue)	***Annual Funding:*** $205 million All Funds ($58.5 million General Revenue)	***Annual Funding:*** GR – $2.9M Fed (CDC and Title XX) - $6.4M Fed (Title XX) - $3M	***Annual Costs:*** $91.2 million All Funds ($26 million General Revenue)

**Excludes Emergency Medicaid - Birth Costs to Undocumented Persons, which provided labor and delivery services for approx.52,000 women in FY13 through emergency services for undocumented persons.*

"Medicaid cost estimate reflects using a per member, per month cost for medical and vendor drug costs for all client risk groups, based on the total number of female clients age 18 and above, as well as older adolescent females (15-17) in the non-disabled Children's and Foster Care groups."

HHS Women's Health Programs

Texas Women's Health Program	Family Planning Program (FP)	Expanded Primary Health Care Program	Title V Prenatal	Medicaid – Women's Services	CHIP Perinatal	Breast and Cervical Cancer Screening	Medicaid for Breast and Cervical Cancer
*Covered Services** pelvic examination, STD screening and treatment, HIV screening, diabetes screening, high blood pressure screenings, cholesterol screenings, breast & cervical cancer screenings, clinical breast exam, pap tests (initial test only), and Contraceptives.	*Covered Services*** pelvic examination, STD screening and treatment, HIV screening, diabetes screening, high blood pressure screenings, cholesterol screenings, breast & cervical cancer screenings, clinical breast exam, pap tests (initial and follow-up testing), and contraceptives.	*Priority Services*** pelvic examination, STD screening and treatment, HIV screening, diabetes screening, high blood pressure screenings, cholesterol screenings, breast & cervical cancer screenings, clinical breast exam, pap tests (initial and follow-up testing), immunizations and contraceptives.*	*Covered Services:* pelvic examination, STD screening and treatment, HIV screening, diabetes screening, high blood pressure screenings, cholesterol screenings, pap tests, prenatal labs, ultra sound, non-stress test, dental services, and post-partum visit.	*Covered Services* Full Medicaid acute care benefits for qualifying women. In addition, pregnant women have access to family planning annual exams, other family planning office or outpatient visits, laboratory services, radiology services, contraceptive devices and related procedures, drugs and supplies, medical counseling and education, sterilization and sterilization-related procedures, prenatal visits, prescriptions, prenatal vitamins, labor and delivery, postpartum visits.	*Covered Services:* Up to 20 prenatal visits, prescriptions and prenatal vitamins, labor and delivery of the baby, two post-partum visits, and regular check-ups, immunizations and prescriptions for the baby after the baby leaves the hospital.	*Covered Services:* pelvic examination, high blood pressure screenings, breast & cervical cancer screenings, clinical breast exam pap tests (initial and follow-up testing) mammograms, diagnostic services for women with abnormal breast or cervical cancer test results, cervical dysplasia treatment, and individualized case management.	*Covered Services* Full Medicaid benefits during active cancer treatment, including cancer related services, such as: diagnostic services, surgery, chemotherapy, radiation, reconstructive surgery, medication (ongoing hormonal treatment), and active disease surveillance.

**Additional EPHC services: mammograms, diagnostic services for abnormal breast or cervical cancer test results, cervical dysplasia treatment, individualized case management, and prenatal medical and dental services.*

***Full Medicaid acute care benefits are only available during pregnancy and up to two months after birth for certain income-eligible women.*

Interim Charge #4- Alternatives to the Affordable Care Act (ACA)

Interim Charge Language: *Identify cost-effective alternatives to Medicaid and the Affordable Care Act to better connect low income individuals to health care services through private market-based solutions, including Medicaid block grants and waivers. Recommendations should strive to encourage cost sharing, promote personal responsibility, reduce uncompensated care costs, contain increasing health care costs, improve access to care, address access to emergency department care issues in rural areas, promote the use of existing private coverage or employee sponsored coverage, reduce non-emergency use of emergency departments, and reduce the need for federal approval to the state Medicaid plan.*

Hearing Information

The Senate Committee on Health and Human Services (HHS) held a hearing on August 14, 2014 to discuss Interim Charge #4 related to alternatives to the Affordable Care Act. Representatives from the Health and Human Services Commission (HHSC), the Department of State Health Services (DSHS), and the Texas Department of Insurance (TDI) provided invited testimony. Nineteen individuals provided public testimony, 10 of whom also provided written testimony. Two individuals provided public testimony in written form only.[1]

Introduction

The Patient Protection and Affordable Care Act (PPACA or ACA) was passed by Congress and signed into law by President Obama on March 23, 2010. This law sought to provide universal health coverage to all uninsured Americans through two mechanisms: the creation of a federal health-insurance marketplace to allow Americans to purchase private, subsidized health plans, and the expansion of Medicaid eligibility to include all persons falling below 138% of the federal poverty level (FPL).

While the national health insurance marketplace went online on October 1, 2013, the proposed expansion of Medicaid was ultimately rendered optional for states, following the Supreme Court's 5-4 decision in *National Federation of Independent Business v. Sebelius*.[2] The Texas Legislature and the Governor have determined that expansion of Medicaid in its current form is not the right choice for Texas. Instead, the state must seek ways to reform the Medicaid program to contain ever increasing costs and increase personal responsibility. Additionally, we must ensure that we have an accurate picture of the healthcare landscape in Texas, including who the uninsured are and what healthcare they are currently able to access, in order to truly determine where there is remaining need for services and how to meet those needs.

Texas Medicaid Program

Medicaid is a jointly-funded state and federal entitlement program that serves some of our state's most vulnerable citizens: pregnant women, children, the elderly, and the disabled. Over the years, this program has experienced dramatic growth in caseloads, and has continued to consume an ever-increasing portion of our state's budget.

- *Caseloads:* Medicaid caseloads have grown from 2.1 million individuals in Fiscal Year 2002 to 3.7 million in Fiscal Year 2014, and are expected to exceed 4.6 million

individuals by Fiscal Year 2017.[3] Based on these projections, caseloads will have grown an astonishing 119% over the fifteen year period from Fiscal Years 2002-2017.

- *Costs:* The costs associated with serving our Medicaid population also continue to grow at an unsustainable rate. In Fiscal Years 2002-2003, Medicaid accounted for 22% ($25.2 billion) of the total state budget.[4] In the Fiscal Years 2014-2015, Medicaid spending accounted for 30% ($57.2 billion) of the total state budget.[5] HHSC has requested $67.9 billion for the Medicaid program in their Legislative Appropriations Request for Fiscal Years 2016-2017, a projected increase of 20% over the current biennium.[6] As ballooning Medicaid costs continue to consume an ever-greater percentage of the state budget, they place an ever-increasing strain on other key budget priorities like water, transportation, and public education.

The state's first order of business must be to repair this broken Medicaid system and bring these costs under control. By enacting common-sense reforms such as cost sharing, health savings accounts, variable benefit packages, and high-deductible emergency care plans, Texas can reform its Medicaid program in a way which contains costs, encourages personal responsibility, and lessens the burden of providing uncompensated care.

Unfortunately, most of these innovative solutions are not able to be implemented under the strict Medicaid guidelines imposed by the federal government. By receiving a federal waiver from these restrictions, Texas can finally have the flexibility it needs to design a sustainable and cost-effective Medicaid program that is appropriate for the citizens it serves and accountable to taxpayers.

Impact of ACA on Texas' Medicaid Program

Despite the decision not to expand Medicaid eligibility in Texas, caseloads and associated costs continue to rise due to other impacts of the ACA. These changes are expected to add over 50,000 individuals to the state's Medicaid caseloads in Fiscal Year 2014 and are anticipated to add more than 1.1 million individuals through Fiscal Year 2017, as illustrated in Table 1:

Table 1: ACA-Related Caseload Additions to Medicaid[7]

ACA-Related Provision	FY 2014	FY 2015	FY 2016	FY 2017
12-Month Recertification		168,016	222,364	244,461
Previously Eligible, Newly Enrolled	39,848	138,694	167,281	170,310
Foster Care to Age 26	1,498	4,952	5,317	5,623
Hospital Presumptive Eligibility	-	4,374	13,433	13,488
Total	**50,239**	**316,037**	**408,395**	**433,881**

- *12 Month Recertification:* Medicaid eligibility is now recertified every 12 months instead of the previous six months.

- *Hospital Presumptive Eligibility:* Beginning in February 2015, hospitals will be allowed to determine eligibility for short-term "presumptive" Medicaid, which allows them to be reimbursed for services while the person awaits a full Medicaid eligibility determination.

- *"Welcome Mat" Effect:* Individuals who were previously eligible for Medicaid but not enrolled are now enrolling in large numbers due to the individual mandate and outreach by advocates and ACA navigators.

- *Foster Care Extension:* Children who age out of foster care are now allowed to remain on Medicaid until age 26 (previously until age 21). This is anticipated to impact a very small group of individuals.

- *Implementation of Modified Adjusted Gross Income (MAGI):* Under the ACA, the methodology for determining income eligibility for Medicaid and the Children's Health Insurance Program (CHIP) changed to MAGI, which does not consider child support payments as part of an applicant's income. The impacts of this change on caseloads have not yet been determined.[8] (Note that this group is not included in Table 1)

As shown above, the ACA is expected to result in dramatically increased Medicaid caseloads and costs -- even without Medicaid expansion.

In 2013, the Texas Legislature enacted a law requiring DSHS to educate low-income Texans about the availability of health coverage and subsidies through the federal health insurance exchange. This law also required DSHS to certify that individuals applying to the state for health services do not have access to private insurance that would otherwise cover those services.[9] Theoretically, the state of Texas would expect to see reduced enrollment in other state-funded safety net programs as individuals either purchase health coverage through the exchange, or enroll for Medicaid benefits, provided they were previously eligible but unenrolled. However, to date, there has been no evidence to suggest that enrollment in other state-funded safety net programs has been significantly reduced due to the ACA.

The Uninsured in Texas

In order to understand the true extent of the uninsured problem in Texas, we must first conduct an accurate assessment who exactly comprises our uninsured population. In 2013, 22.1% of Texans, or 5.5 million individuals, lacked health insurance.[10] Hispanics have the highest uninsured rate (37% in 2012) and account for two-thirds of the total uninsured population.[11] Areas of the state with the highest uninsured rates include the Rio Grande Valley, Dallas County, and rural areas in the panhandle east Texas, and central Texas.[12]

Individuals with incomes falling between 100% and 400% FPL are eligible for federal tax subsidies to purchase health coverage through the health insurance marketplace. Nearly 2 million uninsured Texans, or 28% of the state's uninsured population, are currently eligible to purchase this subsidized health insurance.[13] An additional 1.3 million uninsured Texans either

have health insurance options available through their employer or have incomes exceeding 400% of FPL.[14] Despite having the option to receive health coverage through the methods listed above, these two groups account for nearly half (49%) of Texas' 5.5 million uninsured residents.

As previously discussed, Texas has an estimated 868,000 individuals who are eligible for benefits under the Texas Medicaid program but have not yet elected to enroll.[15] Many of these individuals are expected to join the Medicaid program over the next few years.

Undocumented immigrants represent an additional 1.24 million uninsured individuals, nearly 20% of Texas' total uninsured population.[16] These individuals are ineligible for Medicaid or health coverage under the ACA due to their immigration status. This aspect of our uninsured population is more pronounced in border states like Texas and continues to grow as more individuals cross our southern border illegally or stay beyond the time legally allowed under their visas.

The remainder of Texas' uninsured individuals are those who fall between the state's current Medicaid eligibility level and 100% FPL, when they become eligible for subsidies to purchase private health insurance through the marketplace. There are one million Texans who fall into this coverage gap, accounting for 4.1% of the state's total population.[17] Table 2 shows the breakdown of Texas's uninsured.

Table 2: The Uninsured in Texas, 2012 Data[18]

Population	Number	% of Total Uninsured
Eligible for Marketplace Subsidies (100-400% FPL)	1.7 million	28%
Above 400% FPL or Employer-Sponsored Insurance	1.3 million	21%
Eligible but not Enrolled in Medicaid/CHIP	868,000	14%
Undocumented Immigrants	1.24 million	20%
Coverage Gap	***1.05 million***	***17%***

Impact of ACA on Texas' Uninsured Population

As of April 1, 2014, just 733,757 Texans eligible to purchase health insurance through the federal marketplace had done so.[19] However, some estimates indicate that only about 57% of those who have signed up through the marketplace nationwide were previously uninsured. Applying this proportion to Texas would indicate that only about 400,000 individuals who have gained health insurance through the marketplace were previously uninsured.[20] While not an insignificant number, this figure falls far short of the lofty expectations of the ACA. Furthermore, it remains to be seen how many of these newly-enrolled individuals have actually paid their premiums and how many will continue to stay enrolled over the long-term.

Healthcare Landscape in Texas

Today in Texas, only 31% of healthcare providers accept all new Medicaid patients.[21] Choosing to expand Medicaid benefits to over one million new individuals would threaten to strain the existing provider network past the breaking point, increase wait times, and potentially reduce access for existing Medicaid patients, some of the state's most vulnerable citizens. Clearly,

having health insurance, including Medicaid, is not synonymous with access to timely healthcare.

By the same token, being uninsured does not necessarily equate to a lack of options for receiving health care. In addition to charity care provided by thousands of Texas healthcare providers, and emergency care required by federal law, there are numerous programs and healthcare settings which provide services to the uninsured. This includes Federally Qualified Health Centers, County Indigent Programs, Local Health Departments, health-related institutions, and multiple state-funded programs at DSHS such as women's health programs and mental health and substance abuse programs.

- *Federally Qualified Health Centers (FQHCs)*: FQHCs are safety net organizations that provide primary care to underserved populations. There are 70 FQHCs with 350 clinic sites operating in 118 counties. Collectively, these FQHCs serve 1.1 million individuals annually and handle over 4 million patient visits. Fifty-one percent of FQHC clients are uninsured.[22]

- *County Indigent Programs:* Counties that are not fully served by a public hospital or hospital district are required by state law to provide basic healthcare services to individuals at or below 21% FPL. Counties may choose to raise eligibility up to 50% FPL. The County Indigent Health Care Program (CIHCP) at DSHS provides assistance to counties that spend more than 8% of their general revenue tax levy on health care services.[23] Many hospital districts and larger counties with public hospitals utilize local funds to provide services for individuals at much higher income levels in community clinics in order to reduce unnecessary visits to hospitals, where care is more costly. Several counties have developed robust enrollment-based indigent programs that cover higher income levels but use sliding scale co-pays and deductibles based on income. These programs have been successful in establishing a medical home for clients and reducing uncompensated care costs and overutilization of emergency rooms.[24]

- *Local Health Departments (LHDs)*: LHDs serve as the safety net provider of public health services such as immunizations, HIV/STD screening, and TB tests for the uninsured. These services are provided using a combination of federal, state, and local funds.

- *Health-Related Institutions:* Texas' robust network of health-related institutions and medical schools provide billions of dollars of charity care each year to low-income, uninsured individuals in their communities. In addition to the 10 health-related institutions currently operating in Texas, new institutions are currently under construction in Travis County and the Rio Grande Valley.

- *Women's Health Programs:* The 83rd Legislature provided $215 million in state General Revenue to provide family planning and other preventative health care services to uninsured, low-income women in four programs: DSHS Family Planning, Expanded Primary Health Care Program, Texas Women's Health Program, and the Breast and

Cervical Cancer Services Program.[25] All four of these programs serve women with incomes falling in the coverage gap.

- *Behavioral Health Programs:* The 83rd Legislature provided over $300 million in additional funding for a variety of programs to increase access to mental health and substance abuse services, primarily for individuals who are uninsured or Medicaid eligible.[26]

In addition to these programs that serve the uninsured in Texas, there are 1,491 Delivery System Redesign Incentive Payment (DSRIP) projects being operated as part of the 1115 Medicaid Transformation Waiver that are anticipated to earn $11.4 billion over the five years of the waiver. Almost all of these projects will serve some uninsured individuals, and over the final three years of the project, an estimated 1.5 million uninsured individuals are expected to receive services. It should be noted that the estimated number of uninsured individuals served is not unduplicated, so individuals served over more than one year may be counted twice in this figure.[27]

The state must accurately account for the programs and services listed above in order to determine where need still exists. To this end, HHSC has identified 8,166 providers who may offer reduced-cost or free healthcare services to low-income, uninsured Texans using a survey of community-based organizations, local government, and non-profit organizations. The next phase of the survey, anticipated to be completed in spring 2015, will examine how many uninsured individuals these providers serve, the range of services provided, eligibility requirements, and the cost to clients for services, including any cost-sharing requirements or other payment arrangements.[28] The results of this survey will help the Legislature better assess where outstanding need exists and how to best address those needs.

Conclusion

The Medicaid system is in need of fundamental reform to grant the state desperately needed flexibility if the system is to be sustainable in the future. Expansion of the program in its current form would be irresponsible to Texas taxpayers and would not deliver the increased access to care promised by expansion supporters. Texas should seek increased federal flexibility to operate our Medicaid program, and should support and build upon locally-led programs and institutions that have proven successful in providing care to the uninsured in cost-effective ways.

Recommendations

1. **Texas should encourage congressional action to operate Medicaid as a block grant program and should simultaneously continue to pursue a waiver from the Centers for Medicare and Medicaid Services (CMS) to allow the state increased flexibility in the operation of our Medicaid program.** While the delivery of Medicaid funds through a block grant is ultimately a decision of the U.S. Congress, the state should actively urge such action at the national level. Additionally, HHSC should continue to seek a waiver from CMS that will allow Texas to contain costs and increase personal responsibility by

enacting cost sharing requirements, tailoring benefits to more closely align with individual needs, enhancing efforts to prevent fraud, waste, and abuse, and eliminating unnecessary administrative costs.

2. **Support successful programs and entities that have local buy-in and include local funding sources.**
   - Successful programs that serve the uninsured and are funded through state and local sources, such as mental health services offered through Local mental Health Authorities (LMHAs) and county indigent programs, should be supported and potentially expanded by the Legislature.
   - Programs that enable low-income families to access private market health coverage such as the Health Insurance Premium Payment (HIPP) program should be promoted and expanded. This program reimburses families of Medicaid-eligible clients for their share or a portion of their share of an employer-sponsored health insurance premium, only in cases when the state has determined that paying the premium is more cost-effective than enrolling the Medicaid-eligible family member in the Medicaid program.[29] In Fiscal Year 2013, there were 7,194 active HIPP cases serving 9,657 Medicaid-eligible individuals and 26,409 total clients.[30] Expansion of the HIPP program should be considered as a way to connect family members of Medicaid-eligible individuals to affordable private health insurance.
   - Texas should support settings that serve high numbers of uninsured Texans, such as Federally Qualified Health Centers (FQHCs). FQHCs provide a medical home for many Texans without health insurance. FQHCs are facing a "fiscal cliff" in 2016, when the federally-funded FQHC Trust Fund is expected to be discontinued.[31] Texas should advocate for continued funding for the Trust Fund and supply state funds, as available, to support this vital part of our safety net.

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[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List,* August 14, 2014: http://www.legis.state.tx.us/tlodocs/83R/witlistmtg/pdf/C6102014081411001.PDF
[2] Supreme Court of the United States, Slip Opinion, *National Federation of Independent Business v. Sebelius, Secretary of Health and Human Services, et al*, June 28, 2012.
[3] Health and Human Services Commission, *Medicaid Legislative Appropriations Request Caseload: June 2014 Forecast Overview*, October 29, 2014, p. 3.
[4] Legislative Budget Board, *Fiscal Size-Up 2002-03,* February 2002.
[5] Legislative Budget Board, *Fiscal Size-Up 2014-15,* February 2014.
[6] Health and Human Services Commission, *Consolidated Budget: Fiscal Years 2016-2017*, October 2014.
[7] Health and Human Services Commission and Department of State Health Services, *Presentation to the Senate Committee on Health and Human Services*, August 14, 2014, p. 4.
[8] *Supra* note 3, p. 2.
[9] Senate Bill 1057, 83rd Regular Session, 2013 (Nelson/Zerwas).
[10] Smith, Jessica C. and Carla Medalia, *Health Insurance Coverage in the United States: 2013*, U.S. Census Bureau, September 2014.
[11] Texas Department of Insurance, *Presentation to the Senate Committee on Health and Human Services*, August 14, 2014, p. 10.

[12] *Supra* note 11, p. 11
[13] Kaiser Family Foundation, *How Will the Uninsured in Texas Fare Under the Affordable Care Act?*, January 6, 2014.
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] Texas Department of Insurance, *Presentation to the Senate Committee on Health and Human Services*, August 14, 2014, p. 4.
[20] *Supra* note 19, p. 18.
[21] Texas Medical Association, *Drop in Physician Acceptance of Medicaid, Medicare Patients*, July 9, 2012.
[22] Texas Association of Community Health Centers, *Community Health Centers: Working for Healthy Families and a Stronger Texas,* March 2014.
[23] Texas Health and Safety Code, Chapter 61.
[24] Davidson, John and Emily Poirier, *Policy Perspective: Innovations in Indigent Care: Strengthening the Safety Net in Texas*, Texas Public Policy Foundation, January 2014.
[25] *Supra* note 7, p. 18.
[26] *Supra* note 7, p. 17.
[27] Information provided by Health and Human Services Commission via email, October 2, 2014.
[28] *Supra* note 7, p. 19.
[29] *Supra* note 7, p. 11.
[30] Health and Human Services Commission, Follow-up information from August 14, 2014 hearing, provided August 29, 2014.
[31] Texas Association of Community Health Centers, *Protect Safety Net and Save Money Through Coverage Expansion*, July 2014.

Interim Charge #5- Temporary Assistance for Needy Families

Interim Charge Language: *Evaluate the Temporary Assistance for Needy Families (TANF) program structure. Make recommendations to improve the program's operations and ensure the program achieves outcomes that allow TANF recipients to find employment and achieve self-sufficiency. Recommendations should seek to ensure Texas is using the most effective work-related requirements and drug testing protocols.*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on August 15, 2014 to discuss Interim Charge #5 related to the Temporary Assistance to Needy Families (TANF) program. Representatives from the Health and Human Services Commission (HHSC) and the Texas Workforce Commission (TWC) provided invited testimony. One individual provided public testimony.[1]

Introduction and Background

Cash assistance distributed to beneficiaries in the TANF program serves the important purpose of acting as a temporary safety net for very low-income families with children while they seek gainful employment and strive for self-sufficiency. However, cash assistance is unique among state assistance programs, most of which only allow the purchase of very specific items, such as in the Supplemental Nutrition Assistance Program (SNAP) program, or directly reimburse service providers for services rendered to a beneficiary, such as in the Medicaid program. The unique nature of allowing TANF recipients to directly withdraw cash benefits warrants additional scrutiny by lawmakers to ensure every dollar is being directed to the truly needy and that participation requirements in the TANF program are being met. The state has broad flexibility in the administration of the TANF program, but in return must ensure that the program is achieving its stated goals of keeping children in their homes; promoting job preparation, work and marriage; reducing out-of-wedlock pregnancies; and encouraging the formation of two-parent families.

Federal Welfare Reform

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) eliminated the traditional welfare entitlement program, Aid to Families with Dependent Children (ADFC), and replaced it with TANF, which introduced work requirements for cash assistance beneficiaries and restrictions such as time-limited benefits. PRWORA block granted funding to states, giving them broad flexibility to use TANF funds to meet the goals of the program, and allowed states to enforce stricter program requirements within certain parameters.[2] Additional changes were made through the 2005 federal Deficit Reduction Act to strengthen work participation requirements.[3]

Texas' TANF Program

Texas received approximately $495 million in TANF Block Grant funding in Fiscal Year 2014, about $26.8 million, or 5.4%, of which was allocated for TANF cash assistance.[4] In order to be eligible for cash assistance, an applicant must be a U.S. citizen or eligible documented immigrant, a Texas resident, have a child under the age of 18 living in the home, cooperate with the requirements of the Personal Responsibility Agreement (explained further below) including

work requirements, have an income below 14% of the Federal Poverty Level (FPL), and have a maximum of $1,000 in assets.[5] Although TANF-eligible families who meet certain criteria may opt to receive a one-time cash benefit instead of receiving monthly benefits, the most common form of TANF cash assistance is a monthly grant.[6] Monthly payments are based on family size and income, with the maximum annual benefit amount capped at 17% FPL.[7]

Time Limited Benefits

As allowed by federal law, Texas has chosen to impose stricter requirements on TANF recipients than many other states. The maximum lifetime limit for adults to receive benefits is sixty months and there is no time limit on children up to age 18. However, the limit on the period of *consecutive* months that an adult may receive benefits varies based on an individual's educational attainment and work experience. Specifically, adults are limited to:

- Twelve consecutive months of cash benefits if they have a high school diploma, GED, or a two- or four-year degree from an institution of higher education, or have recent work experience of 18 months or more;
- Twenty-four consecutive months of cash benefits if they have completed three years of high school or have recent work experience of 6 to 18; and
- Thirty-six consecutive months of cash benefits if they have completed less than three years of high school and have recent work experience totaling less than six months.[8]

After these consecutive limits have been reached, a beneficiary is ineligible to reenroll in TANF for five years.[9]

Work Requirements

Adults receiving TANF are required to work at least 30 hours a week or participate for at least twenty hours a week in the TANF employment and training program offered by the Texas Workforce Commission (TWC) known as Choices.[10] Several exemptions to these requirements are established in federal policy, state statute, or agency rule. Additionally, all parents of children receiving benefits who do not receive direct benefits (known as child-only cases) are exempt from work requirements.[11] As of July 2014, over 57% of adults on a TANF case, including parents in child-only cases, were exempt from work requirements.[12] Table 1 shows the percentage of those exempt from work requirements based on specific exemptions. 40.3% of adults on TANF cases are exempt from work requirements simply because they are not receiving TANF benefits themselves (child-only cases). The majority of these individuals are receiving Social Security Income (SSI) and are therefore ineligible to receive TANF benefits directly. However 1,608, or about 10.8% of all adults on TANF cases, have been disqualified from directly receiving TANF because they have reached the sixty month lifetime benefit limit, have a felony drug conviction, or have committed another program violation resulting in their disqualification.[13]

Table 1. Exemptions from TANF Work Requirements, July 2014

Exemption	Number of Individuals	Percentage of Total Adults on TANF Cases (includes child-only)
Parent in a child-only case	5,974	40.3%
Parent or caretaker caring for disabled or ill child in the household	297	2.0%
Parent or caretaker caring for disabled or ill adult in the household	39	0.2%
Single parent or caretaker caring for a child under age 1 at initial application	1,050	7.1%
Parent or caretaker over age 60	38	0.3%
TANF recipient unable to work due to a mental or physical disability expected to last at least 180 days	955	6.5%
TANF recipient who is pregnant and unable to work	69	0.5%
Single grandparents, age 50 and over, who are caring for a child under age 3	15	0.1%
Hardship Exemption	21	0.1%
Total Exempt	**8,458**	**57.2%**

Personal Responsibility Agreement

In order to receive TANF benefits, adult applicants in child-only cases must sign a Personal Responsibility Agreement (PRA), requiring the TANF recipient to agree to:

- Cooperate with child support program requirements;
- Refrain from abusing alcohol and drugs;
- Obtain medical screenings for their children; and
- Ensure their children are immunized and attending school.[14]

Adults applying to receive TANF benefits directly must also agree, through their PRAs, to:

- Meet work requirements, unless exempt;
- Not quit a job; and
- Attend parenting skills classes, if referred.[15]

Sanctions

TANF households who fail to comply with their PRA are sanctioned with the loss of TANF cash assistance for one month or until compliance with the PRA is achieved, whichever is longer. Households failing to comply for two consecutive months lose their TANF eligibility and the household may not receive cash assistance until they have demonstrated compliance with the PRA for 30 full days. Non-compliance with work requirements or child support program requirements also results in the loss of Medicaid coverage for one month or until compliance with the PRA is achieved, whichever is longer. However, Medicaid may not be denied to pregnant adults or children under the age of 19.[16] The TWC reports non-compliance with the Choices program to HHSC unless the recipient is given a "good cause" reason for non-compliance.[17] In Fiscal Year 2013, about 14% of Choices participants were given good cause excuses from participation, the majority due to temporary illness or incapacitation.[18] Table 2

shows the 10 good cause excuses, established through rule, and the number of adults who were granted the excuse in state Fiscal Year 2013.

Table 2. Good Cause Excuses, FY 2013

Good Cause Excuse	Clients Excused	Percent of Choices Participants
Temporary Illness/Incapacity	6,232	11.1%
Court Appearance	20	0.0%
Family Crisis	1,104	2.0%
Lack of Transportation	112	0.2%
Lack of Child Care Resources	48	0.1%
Lack of Any Other Support Services	22	0.0%
No Available Jobs in Reasonable Distance	6	0.0%
Victim of Domestic Violence	85	0.2%
Caring for Family Member Not in School	556	1.0%
Caring for Family Member in School	146	0.3%
Total Excused With Good Cause	**7,778**	**13.9%**

Prior to the passage of House Bill 2292 in 2003 (Wohlgemuth), Texas sanctioned non-compliant recipients by the amount of the adult beneficiaries' cash assistance benefit only, so non-compliant recipients continued to receive their children's portion of the household's TANF payment. House Bill 2292 introduced full-family sanctions for non-compliance with the PRA, which allows the state to terminate the entire family's benefits for one full month or until the family reaches compliance with the PRA, whichever is longer. After this policy change, Texas experienced a dramatic decrease in both overall TANF caseloads and in the number of non-compliant beneficiaries.[19]

Conclusion

Overall, Texas has taken advantage of the flexibilities afforded to states by PRWORA and has designed a TANF program that is accountable to taxpayers and truly serves only the neediest families in the state who are using the program as a temporary safety net to allow them to achieve self-sufficiency. However, there are some additional steps lawmakers should consider pursuing to further improve the integrity of the program, particularly among adults in child-only cases.

Recommendations

1. **Require Drug Screening for adult TANF applicants.**
   Federal law allows states to test and sanction TANF applicants or recipients for drug use. As of July 2014, eleven states had passed drug testing legislation. As envisioned in Senate Bill 11, filed during the 83rd Regular Legislative session, Texas should require TANF applicants to undergo a controlled substance *screening* assessment and require drug *testing* for any TANF applicant who has a felony drug conviction, has previously tested positive, or whose screening assessment indicates good cause to suspect the person

of using controlled substances. Those applicants testing positive for drug use should be disqualified from receiving TANF benefits for a specified period of time, but should be allowed to re-enroll in TANF after completing substance abuse treatment. Any legislation to require drug screening should ensure that if a parent's benefits are discontinued because of the result of a drug test, their children continue to receive benefits through a protective payee, as outlined in the version of SB 11 that passed this committee during the 83rd session.

2. **Remove exemption from work requirements for adults in child-only cases who have been disqualified from TANF for non-compliance or reaching lifetime benefit limits.**
   Parents of children receiving TANF cash benefits who do not directly receive benefits themselves (child-only cases) are exempt from the work requirements imposed on TANF adults who receive direct benefits. As of July 2014, adults in child-only cases who have been disqualified from TANF either because they have reached the sixty month lifetime benefit limit, have a felony drug conviction, or have committed another program violation resulting in disqualification, accounted for 10.8% of all adults on TANF cases. These parents should be required to participate in the workforce or to receive career counseling and training in order to increase their prospects of obtaining gainful employment and achieving self-sufficiency.

3. **Require the Personal Responsibility Agreement (PRA) signed by adults in child-only cases, where applicable, to include a requirement to fulfill work requirements and to attend parenting classes, if referred.**
   Related to recommendation #2, adults in child-only cases who do not qualify for another exemption from work requirements should be required to meet all PRA requirements that currently apply to adults receiving direct benefits, including fulfilling work requirements and attending parenting classes if referred.

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[1]Senate Committee on Health and Human Services, *Interim Hearing Witness List,* August 15, 2014: http://www.legis.state.tx.us/tlodocs/83R/witlistmtg/pdf/C6102014081509001.PDF.

[2] Stout, Mary Katherine, *Policy Perspective: Continuing Welfare Reform in Texas*, Texas Public Policy Foundation, July 2006.

[3] *Id.*

[4] Health and Human Services Commission, H, *Testimony before the Senate Committee on Health and Human Services*, August 15, 2014, p. 3. Full presentation found at: https://www.hhsc.state.tx.us/news/presentations/2014/Senate-Presentation-TANF.pdf

[5] *Id*, p. 6.

[6] *Id*, p. 4.

[7] *Id*, p. 5

[8] Texas Human Resources Code, Sec 31.0065(b).

[9] *Id*, Sec 31.0065(e).

[10] *Supra* note 8, Sec 31.012 (a).

[11] *Id.*

[12] Health and Human Services Commission, *Temporary Assistance for Needy Families (TANF) Program: Adults Not Subject to Work Requirements*, August 2014.

[13] *Id.*

[14] *Supra* note 4, p. 7.
[15] Texas Human Resources Code, Sec 31.0031(d).
[16] *Supra* note 4, p. 8.
[17] Texas Workforce Commission, *Testimony before the Senate Committee on Health and Human Services*, August 15, 2014, p. 3.
[18] Texas Workforce Commission, *TANF Choices Good Cause Reasons in SFY 2013*, provided September 9, 2014.
[19] *Supra* note 4, p. 9.

Interim Charge #6- Prescription Drug Abuse

Interim Charge Language: *Evaluate the current state of prescription drug abuse and strategies for reducing prescription drug abuse in Texas. Make recommendations on how these policies can be improved or modified to enhance the State of Texas' handling of services, treatments and education related to prescription drug abuse and to reduce the overall prevalence of prescription drug abuse.*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on August 15, 2014 to discuss Interim Charge #6 related to prescription drug abuse. Representatives from the Department of State Health Services (DSHS), the Texas Medical Board (TMB), the Texas State Board of Pharmacy (TSBP), and the Texas Department of Public Safety (DPS) provided invited testimony. Two individuals provided public testimony, one of whom also provided written testimony. Four additional individuals provided testimony in written form only.[1]

Introduction and Background

Each year, nearly 15,000 people in the United States die due to a prescription pain medication overdose, and in 2011, the Centers for Disease Control and Prevention (CDC) declared prescription drug abuse an epidemic.[2] Prescription opioids are a class of drug used to manage pain and have side effects of sedation, respiratory depression, and a strong sense of euphoria. Overdose deaths due to prescription opioids such as oxycodone, methadone, fentanyl, and tramadol increased by 21% between 1999 and 2010.[3]

In Texas, deaths related to opioid overdoses peaked in 2006. Since then, the state has made significant progress in battling the prescription drug abuse epidemic. Texas is now ranked 44th in the number of prescription opioid overdose deaths per year and prescribes fewer long-acting and high-dose pain relievers than any other state in the country.[4]

Despite this progress, Texas is ranked 12th in the country for the rate of nonmedical use of prescription opioids and is struggling to reduce abuse rates among certain high-risk populations, particularly pregnant women.[5] Texas should seek to build upon successful programs and policies to continue to reduce abuse of prescription pain medication in Texas and increase services, education, and outreach to address the growing problem of prescription drug abuse among pregnant women.

Existing Initiatives

Texas has taken extensive measures to reduce the prevalence of prescription drug abuse, and should leverage these efforts to further reduce abuse rates in the state.

Pain Management Clinic Certification

In response to the proliferation of clinics prescribing or dispensing prescription drugs inappropriately, commonly known as "pill mills," the 81st Legislature enacted a law in 2009 requiring all pain management clinics in the state to become certified with the Texas Medical Board (TMB) and to renew their certification every two years.[6] TMB may perform unannounced inspections and order the closure of pain management clinics that do not comply

with registration requirements. Since the enactment of this law, TMB has received 816 applications for pain management clinic licensure, 455 of which were initially granted and 121 of which have been renewed. Twenty-six of the 816 applications were denied, 74 were withdrawn, and 94 are still pending.[7]

Department of Public Safety Prescription Monitoring

Texas established a prescription program in the early 1980s to monitor Schedule II and III controlled substance prescriptions by requiring prescribers of these drugs to use serialized triplicate prescription forms. Originally, pharmacists were required to submit one copy of the triplicate forms to the Department of Public Safety (DPS) within 30 days of filling the prescription.[8]

Since that time, Texas's ability to monitor the prescribing and dispensing of controlled substances has been significantly enhanced through subsequent legislation. Pharmacists are now required to submit prescription information for Schedule II-IV drugs within seven days of filling a prescription using an online system created in 2012 and maintained by DPS, known as Prescription Access in Texas (PAT).[9] The list of those who may access information in PAT has been expanded to include relevant state licensing boards, law enforcement, physicians, pharmacists, veterinarians, dentists, advanced practice nurses, physicians' assistants, pharmacy technicians acting at the direction of a pharmacist, and registered nurses and licensed vocational nurses acting at the direction of a physician.[10]

PAT has the potential to be a very effective tool in the state's fight against prescription drug abuse, but is currently not reaching its full potential. The primary problem is where the program is currently housed. DPS is responsible for the monumental tasks of combating crime and terrorism, assisting with statewide emergency management, and ensuring public safety. The agency does not have the bandwidth to focus their attention on prescription monitoring, and the online program has not progressed in terms of usability or interactive features since its creation in 2012. Additionally, PAT users are not currently able to see data on prescriptions filled in other states, which would be possible if Texas joined the national Prescription Monitoring Program. The state should authorize the relevant state agencies to join the national program to enhance our ability to track Texas prescriptions for controlled substances and to exchange best practices with other states.

Controlled Substance Registration Permit

In addition to registering with the federal Drug Enforcement Agency (DEA), prescribers must also obtain a Controlled Substance Registration (CSR) permit from DPS in order to prescribe controlled substances. The 83rd Legislature passed legislation requiring CSR permit renewal for physicians to occur every two years rather than every year to coincide with the annual renewal process for a medical license obtained through TMB. This legislation also allows physicians to renew their CSR permit online from TMB at the same time they renew their medical license, reducing administrative burden on providers.[11] The state should consider synchronizing the renewal processes for other practitioners who obtain both a CSR permit and a license to practice, such as advanced practice nurses and physicians' assistants.

Neonatal Abstinence Syndrome

Neonatal Abstinence Syndrome (NAS) occurs when newborns experience sudden withdrawal symptoms at birth after being exposed to prescription drugs in the womb. The incidence of NAS has increased significantly in recent years. The number of Texas babies born on the Medicaid program with NAS increased by 18% from Fiscal Year 2011 to Fiscal Year 2013. A baby born with NAS has an average inpatient hospital cost of over $31,000, compared to $12,000 for a baby born without NAS.[12] More importantly, the symptoms of NAS such as tremors, seizures, vomiting, and hyperactive reflexes are painful and debilitating for infants and can last for up to six weeks. Longer term impacts can result from low birth weight and related developmental delays.[13] Texas should take steps to reduce the rate of NAS in Texas by enhancing outreach and education for providers and pregnant women and targeting interventions to support pregnant women with opioid addictions.

Conclusion

Texas has made great strides in reducing the rate of deaths due to prescription opioid abuse and creating a system than ensures accountability for prescribers and dispensers of prescription drugs. However, the state should seek to enhance the usefulness of existing tools such as PAT and increase the focus on prevention and treatment of prescription drug abuse among pregnant women.

Recommendations

1. **Transfer the PAT system and associated appropriations from DPS to the Texas State Board of Pharmacy (TSBP).**
   The TSBP regulates pharmacists, the dispensers of prescription opioids, making them a sensible agency to house and maintain PAT. Similar programs in other states are typically housed at the Pharmacy Board or at a health-related state agency. The TSBP will be able to devote the time, staff, and resources needed to enhance the usability of the program.

2. **Give TSBP authority to join the national Prescription Monitoring Program (PMP) InterConnect.**
   The National Association of Boards of Pharmacy (NABP) Prescription Monitoring Program (PMP) InterConnect facilitates the transfer of prescription monitoring program data securely across state lines to authorized users. It allows participating state prescription monitoring programs across the country to be linked, enabling them to track prescriptions written in one state and filled in another. Half of all states are now participating, allowing authorized users in those states to see a more complete history of patients' controlled substance prescriptions and providing a more effective means of combating drug diversion and drug abuse nationwide.

3. **Enhance usability of the PAT system by enabling the TSBP to make the following changes:**
   - Create push notifications to notify current PAT users when certain criteria for a patient is met that may indicate doctor shopping, such as obtaining and filling prescriptions from multiple providers;

- Allow data to be integrated into electronic health records; and
- Automatically notify pharmacies via PAT if a physician's prescriptive identity has been compromised.

4. **Automatically register providers in PAT upon receipt or renewal of their Controlled Substance Registration permit to encourage use.**

5. **Align the Controlled Substance Registration permit for advanced practice registered nurses and physicians' assistants with license renewal, similar to the aligning of these requirements for physicians in House Bill 1803, 83rd Regular Session.**

6. **Enhance services, education, and outreach to communities and providers in order to reduce the prevalence of and treat the symptoms of NAS.**

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[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List,* August 15, 2014: http://www.legis.state.tx.us/tlodocs/83R/witlistmtg/pdf/C6102014081509001.PDF.
[2] Centers for Disease Control and Prevention, *Prescription Painkiller Overdoses in the U.S*., November 2011.
[3] Office of National Drug Control Policy, *Fact Sheet: Opioid Abuse in the United States*, February 11, 2014.
[4] U.S. Department of Health and Human Services, *Texas: The Rx Opioid Overdose Epidemic*, 2013.
[5] *Id.*
[6] Senate Bill 911 , 81st Regular Session, 2009 (Williams/Hamilton).
[7] Texas Medical Board, *Testimony before the Senate Committee on Health and Human Services*, August 15, 2014, p. 12.
[8] Senate Bill 394, 67th Regular Session, 1981 (Farabee/Grubbs).
[9] House Bill 1070. 75th Regular Session, 1997 (Van de Putte/Madla) and Senate Bill 1879, 80th Regular Session, 2007 (Williams/Hamilton).
[10] Texas Health and Safety Code, Chapter 481.076.
[11] House Bill 1803, 83rd Regular Session, 2013 (Callegari/Huffman).
[12] Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, August 15, 2014, p. 19.
[13] U.S. National Library of Medicine, National Institutes of Health, Neonatal Abstinence Syndrome, accessed 10/19/2014 at: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0004566/

Interim Charge #7- Implementation

Interim Charge Language: *Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services, 83rd Legislature, Regular Session, and make recommendations for any legislation needed to improve, enhance, and/or complete implementation, including but not limited to:*

- *Monitor implementation of initiatives aimed at improving the quality and efficiency of Medicaid long-term care services and supports, including the redesign of services for individuals with intellectual and developmental disabilities.*
- *Monitor implementation of initiatives aimed at reducing fraud, waste, and abuse in Texas Medicaid and other health and human services programs.*
- *Dental Board Reforms: Monitor implementation of initiatives aimed at improving the State Board of Dental Examiners' ability to protect public safety, including strengthening the Board's authority and enforcement powers, improving the complaint review and resolution processes, and increasing staffing to improve the Board's ability to respond to complaints and potential fraudulent activity. Determine whether there are additional changes necessary to ensure that the Board is able to regulate the practice of dentistry and ensure public safety.*
- *Cancer Prevention and Research Institute: Monitor implementation of initiatives aimed at restructuring the governance structure, eliminating conflicts of interest, and increasing transparency at the Cancer Prevention and Research Institute of Texas (CPRIT).*

Hearing Information

The Senate Committee on Health and Human Services held a hearing on August 14, 2014 to discuss Interim Charge #7 related to monitoring implementation passed by the 83rd Legislature.[1] The following testimony was provided on each provision of the interim charge:

- *Part 1 (SB 7, Nelson, 83rd Legislature):* Representatives of the Health and Human Services Commission (HHSC) provided invited testimony. Fourteen individuals provided public testimony, eight of whom also provided written testimony. One individual provided testimony in written form only.
- *Part 2 (SB 8, Nelson, 83rd Legislature):* Representatives from HHSC provided invited testimony. Four individuals provided public testimony.
- *Part 3 (HB 3201, Kolkhorst/Nelson, 83rd Legislature):* A representative from the Texas State Board of Dental Examiners provided invited testimony.
- *Part 4 (SB 149, Nelson, 83rd Legislature):* A representative from CPRIT provided invited testimony. One individual provided public testimony as well as written testimony.

Introduction and Background

The legislative initiatives identified in the interim charge language represent some of the most significant statutory changes passed by the Senate Committee on Health and Human Services during the 83rd Regular Legislative Session. Collectively, they will have a profound impact on a variety of stakeholders: Texans with Intellectual and Developmental Disabilities (IDD) and those residing in nursing facilities; providers of services in the Medicaid program; the dental workforce; cancer researchers funded by the Cancer Prevention and Research Institute of Texas

(CPRIT); and the taxpayers of Texas, who bear the burden of funding these various initiatives and programs and have entrusted the Legislature with ensuring those taxpayers dollars are used in an efficient and transparent manner.

Some of the major provisions of these legislative initiatives will not be implemented for months or even years. The Committee will continue to monitor implementation to ensure legislative intent is being accomplished and to identify any need for legislative clarification or further statutory changes.

The following is a brief overview of the goals of each piece of legislation, as well as a progress chart showing the implementation status of the major provisions of each bill.

Senate Bill 7: Medicaid Long Term Services and Supports (LTSS) Redesign

Senate Bill 7 was intended to improve the coordination of Medicaid acute care LTSS, redesign the LTSS system to more efficiently serve individuals with IDD, and expand on quality-based payment initiatives to promote quality care in the Medicaid program. As of the publication of this report, two major provisions of this legislation have been implemented: the integration of acute care services for individuals with IDD in STAR+PLUS, the Medicaid managed care program for the delivery of acute and long-term services and supports for individuals with disabilities or who are 65 and older; and the expansion of STAR+PLUS to rural areas of the state.

The rollout of these initiatives has been largely successful in terms of ensuring adequate provider networks and continuity of care. However, the expansion of managed care for this vulnerable population represents a profound change for consumers and providers, and the state must be extremely diligent in ensuring a smooth transition. Other significant changes enacted through Senate Bill 7, including the carve-in of nursing facility services into managed care, will occur in early 2015. HHSC and the Department of Aging and Disability Services (DADS) must ensure they are well-prepared for this and other Senate Bill 7 initiatives that will impact a large population of vulnerable Texans, as well as providers. A crucial element of this preparation is ongoing, frequent, and open communication with those impacted by these changes, including consumers, their families, advocates, and providers.

Major Provision[2]	**Required Implementation Date**	**Implementation Status as of 9/1/14**
Created three new Advisory Committees and added membership to an existing Committee to ensure stakeholder input into the expansion of managed care.	10/1/13 (No specified date for STAR Kids Committee)	The following Advisory Committees have been appointed and meetings are ongoing: • IDD System Redesign Advisory Committee • STAR Kids Managed Care Advisory Committee • STAR+PLUS Quality Council Membership was added to the

		following Committee and meetings are ongoing: • State Medicaid Managed Care Advisory Committee
Expands STAR+PLUS to the Medicaid Rural Service Areas (MRSAs).	9/1/14	STAR+PLUS was rolled out to MRSAs on 9/1/14 as required. 52% of eligible enrollees chose a managed care plan prior to the deadline. The remainder were auto-enrolled in a plan.
Integrates acute care services for adults with IDD into STAR+PLUS.	9/1/14	Acute care services for adults with IDD were rolled into STAR+PLUS on 9/1/14 as required. 63% of the IDD population in MRSAs and 52% of the IDD population in non-MRSA regions chose a managed care plan prior to the deadline.
Provides basic attendant and habilitation services to individuals with IDD currently waiting for waiver services.	3/1/15	HHSC has submitted a proposal to the Centers for Medicare and Medicaid Services (CMS) and is awaiting approval. If approved, attendant and habilitation services will be available to over 11,000 individuals who are currently waiting for services.
Carves nursing facility services into STAR+PLUS.	3/1/15	HHSC is working to ensure that the agency is prepared to do the following by the implementation date: • Ensure Managed Care Organizations (MCOs) pay claims within 10 days and allow a full year for claims submissions; • Set the minimum reimbursement rate paid to nursing facilities, including a staff enhancement rate; and • Establish a portal for claims submission.
Directs HHSC to establish a dual demonstration project for individuals enrolled in Medicaid and Medicare.	3/1/15	CMS approved the Texas Dual Demonstration Project in May 2014 and signed a Memorandum of Understanding with HHSC.
Directs HHSC and DADS to develop and implement a new functional assessment tool that will more accurately assess the needs of individuals with IDD.	No later than 2016	DADS recently released a Request for Information (RFI) to evaluate intellectual and developmental disability assessment instruments.

Directs HHSC and DADS to develop and implement one or more pilot programs with providers of IDD services to test capitated service delivery models.	9/1/16	HHSC and DADS are in the planning stage of creating the IDD pilot program.
Directs HHSC to create the STAR Kids managed care program to serve children who receive Supplemental Security Income (SSI) or home and community based waiver services.	9/1/16	HHSC posted a Request for Proposals (RFP) for establishment of the STAR Kids program in July 2014, and the RFP is due in October 2014. The contract effective date is scheduled for 9/1/15.
HHSC must determine whether to transition benefits provided through the Texas Home Living (TxHmL) waiver to STAR+PLUS based on the experience of the IDD Capitated Delivery Model Pilot and the provision of attendant and habilitative services in STAR+PLUS.	9/1/17	HHSC will not be able to begin work on this provision until the IDD Pilot and attendant and habilitation services expansion has been implemented.
HHSC must determine whether to transition benefits provided through Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF-IIDs) and all long-term services and supports waivers other than the Texas Home Living (TxHmL) waiver to STAR+PLUS based on the experience of the IDD Capitated Delivery Model Pilot and the provision of attendant and habilitative services in STAR+PLUS.	9/1/20	HHSC will not be able to begin work on this provision until the IDD Pilot and attendant and habilitation services expansion has been implemented.
Allows HHSC to provide MCOs increased flexibility to implement quality initiatives with their providers.	No specified date	HHSC is leading a workgroup that includes MCOs to explore provider incentives.

Senate Bill 8: Medicaid Fraud, Waste, and Abuse

Senate Bill 8 was intended to enhance the state's ability to detect and prevent fraud, waste, and abuse in health and human services programs, particularly Medicaid, the Children's Health Insurance Program (CHIP), and Emergency Medical Services (EMS). Prior to the 83rd Legislative session, there were extensive reports of fraud in the Medicaid program, particularly among dental, orthodontia, EMS, and therapy providers. The provisions of Senate Bill 8 attempted to give HHSC and the Office of Inspector General (OIG) the tools necessary to proactively identify and investigate fraud, waste, and abuse. Equally as important, Senate Bill 1803 (Huffman, 83R) sought to ensure due process for providers accused of committing fraud, waste, or abuse in the Medicaid program.[3] Together, these bills have the potential to weed out fraudulent providers who drain resources from the Medicaid program, while protecting the vast majority of Medicaid providers who are not involved in fraudulent activity and seek to provide quality services to a vulnerable population of patients.

Major Provision[4]	**Implementation Due Date**	**Implementation Status as of 9/1/14**
Authorized the OIG to employ and commission five peace officers.	9/1/14	The OIG has filled all five of the peace officer slots.
Required the OIG to review its process for investigating fraud, waste and abuse in the Supplemental Nutrition Assistance Program (SNAP) and issue a report to the Legislature on strategies to reduce fraud, waste and abuse in the SNAP program.	9/1/14	The OIG hired a new director to oversee SNAP investigations and review processes used to investigate SNAP cases. The required report was issued on 9/1/14.
Directed HHSC to transition the Medical Transportation Program (MTP) to a full-risk, capitated model in which services are provided on a regional basis through contracted Managed Transportation Organizations (MTOs).	9/1/14	The new MTP delivery model was implemented on 9/1/14, with six vendors selected to serve as MTOs. HHSC is closely monitoring the performance of these contracts to ensure wait times for clients are reasonable and to ensure access during peak hours.
Directed HHSC to create a data analysis unit to establish, employ, and oversee data analysis to improve contract management, detect data trends, and identify anomalies related to services utilization, providers, payment methodologies, and compliance with requirements in Medicaid/CHIP contracts.	As soon as practicable after the effective date of 9/1/13	The data analysis unit has been established and six staff members have been hired. Members of the data analysis unit have been added to contract management teams to build analysis skills used in contract management.

Prohibits certain provider marketing activities under Medicaid/CHIP including unsolicited personal contact with clients and their parents.	Not specified	Rules implementing these provisions went into effect on July 6, 2014. HHSC has published guidelines to assist providers in assessing their compliance with these rules.
Requires HHSC to establish a process for providers to submit proposed marketing materials and activities to HHSC for review and approval.	Not specified	HHSC has published information to inform providers of the option of submitting marketing materials to HHSC for review and approval.
Directs HHSC to periodically review the prior authorization and utilization review processes used within Medicaid to reduce the authorization of unnecessary and inappropriate use of services.	Not specified	HHSC has requested additional staff in their Fiscal Years 2016-17 Legislative Appropriations Request to enable them to implement this requirement.
Made changes to the licensure and regulation of Emergency Medical Services.	9/1/13	All changes have been implemented, and a report from the Department of State Health Services (DSHS) on the effect of these regulations is due on 12/1/14.
Directed HHSC to conduct a joint review with the Department of State Health Services (DSHS) and the Texas Medical Board (TMB).	1/1/14	Report was issued in March 2014.

House Bill 3201: Dental Board Reform

House Bill 3201 was intended to reform the Texas State Board of Dental Examiners' complaint review and resolution processes, strengthen the Board's authority and enforcement powers, and increase staffing to improve the Board's ability to respond to complaints and prevent fraud. In 2012, it took over 400 days to resolve complaints at the Dental Board.[5] One reason for this backlog was an insufficient number of staff at the Board. In addition to the changes made through House Bill 3201, the 83rd Legislature significantly increased funding to allow the Board to hire additional staff in order to resolve complaints in a more timely and efficient manner. At the beginning of Fiscal Year 2014, it took an average of 341 days to resolve complaints. As of late July 2014, that was down to 313 days.[6] Although case lengths are decreasing, the Board should continue to utilize the additional staff funded by the Legislature to further reduce average case lengths.

Major Provision[7]	**Implementation Due Date**	**Implementation Status as of 9/1/14**
Established a $55 surcharge on initial and renewal dental licenses to provide additional staff for the Dental Board's enforcement program.	9/1/13	Rules were amended in August 2013 to comply with this provision and the surcharge is being collected.
Required the Dental Board to inform license holders of the specific allegations against them.	12/1/13	Rules were amended in December 2013 to comply with this requirement.
Prohibited a member of the Board from expressing an opinion or serving as an expert witness in a lawsuit involving a licensee.	12/1/13	Board members have been advised of these requirements and Board staff continue to monitor compliance.
Required the Board to establish expert panels to assist with complaints and investigations relating to professional competency.	12/1/13	Rules were adopted in December 2013 to comply with this requirement. A Dental Review Panel will assist in the review of complaints received on or after January 1, 2014.
Required the Board to complete a preliminary investigation of complaints within 60 days to determine if a full investigation is necessary.	12/1/13	Rules were adopted in December 2013 to implement this requirement. This has resulted in 86 standard of care complaint cases being closed between 1/1/14 and 8/13/14, compared to 6 cases closed during that period in the previous year.
Allowed a parent or guardian to be present in the treatment room during their child's dental treatment, unless the dentist determines that the presence of a parent or guardian is likely to have an adverse effect on the treatment or the child.	12/1/13	Rules were adopted in December 2013. Additional rules requiring documentation in a patient's record if a dentist determines that the presence of a parent or guardian is likely to have an adverse effect on the treatment or the child were adopted in August 2014.
Required the Board to send a license holder notice of an informal settlement conference at least 45 days before the conference, and requires the license holder to submit his or her rebuttal at least 15 days before the conference.	12/1/13	Rules were adopted in December 2013 to implement this requirement.
Allowed the Board to resolve certain complaints with a remedial plan.	12/1/13	Rules were adopted in December 2013 to allow for remedial plans, and the Board has developed a formal

		process to resolve complaints with non-disciplinary action when appropriate.
Required the Board to collect additional information from dentists regarding their practice and business relationships.	11/1 of each even numbered year	Rules were amended in August 2013 and April 2014 to comply with this requirement. The Board has collected information from more than 98% of renewing dentists. A report detailing the results of this data collection will be issued on November 1, 2014.
Required Dental Service Organizations (DSOs), if requested by the Board, to provide the address of the locations where the DSO provides dental services in the state and the name of each dentist providing services at each location.	11/1 of each even numbered year	The Board is compiling a list of DSOs based on the information they collected from dentists (see previous provision) and will collect information from DSOs in 2015.

Senate Bill 149: CPRIT Reforms

Senate Bill 149 was intended to prevent future conflicts of interest in the operations of the agency and the awarding of grants, restructure the leadership at the agency, and increase transparency. When voters approved Proposition 15 in 2007 to provide $3 billion over ten years for research that will find the causes of and cures for cancer, they placed their trust in the Legislature and in CPRIT. Unfortunately, serious lapses in judgment and the failure of leadership at the Institute to follow rules and statutory requirements threatened to shatter that trust in 2013. Senate Bill 149 sought to enact an iron-clad system of checks and balances to prevent such lapses from occurring in the future. The newly appointed leadership of CPRIT has done an admirable job of implementing these reforms and ensuring transparency in the Institute's operations. CPRIT must continue to hold its employees, peer reviewers, and Board members to a high ethical standard, while moving forward to meet the promises made to taxpayers who voted yes for Proposition 15.

Major Provision[8]	Implementation Due Date	Implementation Status as of 9/1/14
Restructured CPRIT leadership, including the establishment of a Chief Executive Officer.	12/1/13	The Chief Executive Officer was hired on 4/14/14.
Established a Compliance Program and Compliance Officer to ensure all rules and laws are followed.	As soon as practicable after the effective date of 6/14/13	A Chief Compliance Officer has been in place since 8/1/12. The Compliance Officer is working with an external consultant to design and implement a Compliance Program.

Required the appointment of a new Oversight Committee and removed the Comptroller and Attorney General as members of CPRIT's Oversight Committee.	As soon as practicable after the effective date of 6/14/13	A new Oversight Committee was appointed in November 2013.
Strengthened conflict of interest policies and codes of conduct to ensure that all grant decisions are free from real or apparent conflicts of interest.	1/1/14	Rules were adopted on 1/24/14. Peer review members, Program Integration Committee (PIC) members, and Oversight Committee members with a conflict of interest must recuse themselves from any discussion or vote on the grant in question. Members of the PIC and Oversight Committee must also disclose any conflict of interest in an open meeting of the Oversight Committee. The Code of Conduct was revised to reflect changes in SB 149 on 9/25/13.
Clarified the process for certifying matching funds.	Rules required to be adopted as soon as practicable after the effective date of 6/14/13	Rules were adopted on 1/24/14. In addition to certification of matching funds, CPRIT requires grantees to verify the expenditure of matching funds at the end of each project year.
Gave responsibility for the creation of recommended grant award "slates" (based on peer review recommendations) to a five member Program Integration Committee (PIC).	Rules required to be adopted as soon as practicable after the effective date of 6/14/13	Rules were adopted on 1/24/14. The PIC was established immediately upon passage and submitted its first slate to the Oversight Committee in February 2014.
Prohibited individuals or entities who make donations to CPRIT or a foundation supporting CPRIT from receiving grants.	Rules required to be adopted as soon as practicable after the effective date of 6/14/13	Rules were adopted on 1/24/14. Grant applicants must certify that they have not and will not make a donation to CPRIT or a foundation supporting CPRIT. All awards made prior to passage of SB 149 were cross-checked against a donor list and donations were returned to five individuals.
Requires CPRIT to adopt rules outlining the qualifications required for a trained patient advocate to act as a peer review committee	Rules required to be adopted as soon as practicable after	Rules were adopted on 1/24/14. Beginning with applications submitted following the enactment of SB 149, trained patient advocates

member.	the effective date of 6/14/13	were added to peer review committees for scientific research and product development grants. Prevention peer review committees have included trained patient advocates since 2010.
Required grantees to repay their funding plus interest to CPRIT if they are out of compliance with the terms of their contract and fail to complete a remediation plan.	Rules required to be adopted as soon as practicable after the effective date of 6/14/13	Rules were adopted on 1/24/14. No grantees have been required to repay grant funding based on this provision as of 11/1/14.

Conclusion

Overall, the implementation of these major pieces of legislation--Senate Bill 7, Senate Bill 8, House Bill 3201, and Senate Bill 149-- has gone smoothly. However, the Legislature and this Committee must continue to closely monitor ongoing implementation efforts and ensure the successful implementation of provisions that have not yet gone in to effect, particularly those that will impact vulnerable citizens, such as those with IDD and those residing in nursing facilities. There are also some additional steps that can be taken to further fulfill the legislative intent of these initiatives.

Recommendations

Senate Bill 7:

1. **HHSC should carefully and continuously monitor the adequacy of the acute care provider network for the IDD population in STAR+PLUS and focus on developing that network in all areas of the state.** The agency has encouraged partnerships between Managed Care Organizations (MCOs) and health-related institutions of higher education to conduct outreach and education designed to attract more physicians to serve the IDD community. Three such partnerships are in development, and one partnership has resulted in a planned $2 million outreach and education effort on the health related institution's campus.

2. **HHSC should continue and enhance communications with consumers, families, providers, and advocates impacted by the expansion of managed care for the IDD population to proactively identify and address issues.** The agency, the ARC of Texas, and local IDD authorities are holding nine community meetings in late 2014 to hear from consumers, advocates, and providers about ongoing issues with the rollout of STAR+PLUS into MRSAs and the integration of acute care services for individuals with IDD into STAR+PLUS. The agency should continue to ensure opportunities for stakeholders to provide input and to work with consumers, families, and providers to identify and address issues with managed care expansion.

<u>Senate Bill 8:</u>

1. **HHSC should continue to carefully monitor the performance of MTOs contracting with the agency to provide services in MTP to ensure clients receive timely access to transportation and to ensure transportation providers are appropriately staffed during peak hours of demand for services.**

2. **Continue to improve the regulation of the EMS industry to reduce the incidence of fraud, waste and abuse. Specifically:**
    - Enact whistleblower protections for EMS personnel who report violations to the state oversight agencies;
    - Require prior written approval from a governmental authority in the area in which an EMS provider plans to operate prior to expansion of an existing EMS provider's service area; and
    - Direct DSHS to determine the potential benefits of regulating non-medical stretcher and wheelchair transportation in Texas as a means to reduce fraud and contain costs.

<u>Dental Board Reform (HB 3201):</u>

The Texas State Board of Dental Examiners should:

- Clarify its existing statutory authority to regulate the activities of non-dentists which impact the practice of dentistry, and identify potential statutory changes necessary to effectively prohibit undue influence on dental practices;
- Continue to improve transparency in their rule-making process; and
- Continue to utilize the increased Full-Time Equivalent employees (FTEs) appropriated by the 83rd Legislature to further reduce the average time that cases are open and the number of unresolved complaints.

<u>Cancer Prevention and Research Institute of Texas (SB 149):</u>

CPRIT should:

- Continue to operate the agency and the Oversight Committee in a transparent way and allow for ongoing public input; and
- Begin developing a plan to transition the Institute to a fully self-sufficient entity by their Sunset date of 2021, as envisioned when the agency was created.

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[1] Senate Committee on Health and Human Services, *Interim Hearing Witness List,* August 14, 2014: http://www.legis.state.tx.us/tlodocs/83R/witlistmtg/pdf/C6102014081411001.PDF

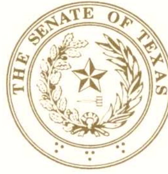
[2] Health and Human Services Commission, *Testimony Before the Senate Committee on Health and Human Services on Senate Bill 7*, August 14, 2014.

[3] Senate Bill 1803, 83rd Regular Session, 2013 (Huffman/Kolkhorst).

[4] Health and Human Services Commission and Department of State Health Services, *Testimony Before the Senate Committee on Health and Human Services on Senate Bill 8*, August 14, 2014.

[5] House Research Organization, Bill Analysis of House Bill 3201, May 2, 2013.

[6] Texas State Board of Dental Examiners, Letter to Senate Committee on Health and Human Services, September 8, 2014.
[7] House Bill 3201, 83rd Regular Session, 2013 (Kolkhorst/Nelson).
[8] Senate Bill 149, 83rd Regular Session, 2013 (Nelson/Keffer).



The Senate of The State of Texas

November 25, 2014

The Honorable
Senator Charles Schwertner, Chair
Senate Health and Human Services Committee
Texas Legislature
Austin, Texas 78711

Dear Chair Schwertner:

Thank you for your leadership as Chair of the Senate Health and Human Services Committee. It is our privilege to serve with you, and we appreciate the opportunity to share our perspectives regarding the Committee's interim report. Because the report includes many fine recommendations that could improve the quality of health and human services for Texans, we are delighted to sign it; however, we submit this letter to be included in our interim report as a record of some of our concerns.

First, we have some reservations regarding the conclusion of Charge 1 to "fully" support and endorse the recommendations adopted by the Sunset Advisory Commission. While much work has been done to identify and address systemic problems and possible solutions, the entire committee has not had an active role in the Sunset process. Including this endorsement in the committee report should not be unconditional, but, rather, should depend on further examination of the Sunset review and any policy recommendations that result. Additionally, Senator West would like to make clear that his support of the recommendations adopted by the Sunset Advisory Commission at their August 13 decision meeting is not an endorsement of the results of the report on statutory barriers undertaken by the Department of Family and Protective Services in compliance with Sunset Recommendation 2.2.

Second, because women's health services are vital to supporting Texas families, we are encouraged by the recommendations for Charge 3. We would be remiss, however, not to express our concerns regarding the potential to narrow eligibility requirements that could result from changes to the programs, including moving all three under one agency. What's more, we believe the report should identify the need to provide more support to recruit and retain providers participating in the state's family planning and women's health programs. The state will need to do more than streamlining the

programs to ensure that providers are set-up for success to treat their patients under the state's programs.

Third, while we appreciate the opportunity to study Charge 4 as members of the committee, we must stress the importance of accepting all funds that are available under the Affordable Care Act to help cover and decrease our uninsured population.

Texas has more uninsured persons than any other state. Hardworking Texans pay an average of $1,800 per year to pay for the health care of those who are uninsured. [1] Care to the uninsured is often provided in one of the most expensive settings available—the emergency room. When the patient is discharged, any unpaid charges are considered uncompensated care. Texas hospitals absorb or pass along to other consumers the large costs attributed to providing uncompensated care. In 2013, for example, Baylor University Medical Center lost $172.8 million, Texas Health Presbyterian Hospital lost $86.5 million, and Parkland Health and Hospital System provided an astounding $1.488 billion of uncompensated care.[2]

The committee report takes issue with the rising number of persons enrolled in the Medicaid program. Although having a large population that meets such low-income qualifications is not a position the State of Texas prefers to be in, insuring this population is of the utmost importance, especially because most of those persons enrolled since 2002 are children.[3]

Clearly, Texas needs a solution that allows our tax dollars to help our most vulnerable populations, including those who fall into what is referred to as the "coverage gap." This coverage gap comprises the working poor who earn more than the amount allowed for Medicaid, but not enough to afford private coverage.

We are equally concerned that veterans often fall into the coverage gap. Failure to draw-down funding available under the Affordable Care Act is depriving more than

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[1] Texas Hospital Association, Did you know? (n.d.). Retrieved November 21, 2014, from http://texasway.org/
[2] Landers, J. (2014, November 17). Hospitals seek a Texas Way to expand Medicaid. *The Dallas Morning News*. Retrieved November 20, 2014, from http://www.dallasnews.com/business/columnists/jim-landers/20141117-hospitals-seek-a-texas-way-to-expand-medicaid.ece
[3] Health and Human Services Commission. *Presentation to Texas House Appropriations Committee, 2013* [PDF Document]. Retrieved November 24,2014 from: http://www.hhsc.state.tx.us/news/presentations/2013/house-appropriations-comm.pdf

49,000 Texas veterans who have served our country admirably the access to the care they need.[4]

Without drawing-down federal funding, Texans are in effect being taxed twice: once when we send our hard-earned tax dollars to Washington and again when we absorb the cost of the uncompensated care delivered at our emergency rooms. We believe the state should adopt a realistic approach that fits the needs of Texans while closing our coverage gap—whether that is "a Texas solution" or a solution by any other name—as long as it puts the dollars to work immediately.

The Texas Institute of Health Care Quality and Efficiency, a fifteen-member board of health professionals appointed by the Governor, recently recommended that the state cover low-income Texans with money available under the Affordable Care Act.[5] Accordingly, we hope that the legislature will pass bipartisan legislation, establishing a framework for negotiations with the Federal Government.

Finally, Temporary Assistance for Needy Families (TANF) is a program available to help the poorest of our families cover expenses necessary to help keep the family together and allow parents the opportunity to rear their children in their own home. With the average recipient receiving only $76 per month, TANF is available only to families that include children, and the maximum income a person can earn to receive cash assistance is $188 per month.[6] We fear that Texas has lost sight of the fact that children are the central and most important beneficiaries of this program.

To achieve savings and increase accountability, previous legislatures have continually increased the requirements placed on TANF recipients. When the parent fails to comply, the children suffer. While instituting compliance requirements may appear to save the state funding on the front end, depriving a child of a healthy upbringing will cost the state in the years that follow in the form of increased health care costs, mental health expenses, and, in some cases, in the criminal justice system. Plain and simple, we cannot afford to be penny-wise, and pound-foolish.

[4] Urban Institute, "Uninsured Veterans and Family Members: State and National Estimates of Expanded Medicaid Eligibility Under the ACA," March 2013

[5] Walters, E. (n.d.). Perry-Appointed Board Backs Health Coverage Expansion. Retrieved November 20, 2014, from http://www.texastribune.org/2014/11/12/perry-appointed-board-endorses-coverage-expansion/

[6] www.hhsc.state.tx.us/news/presentations/2014/Senate-Presentation-TANF.pdf

A review of TANF program structure should have considered how we can encourage participation among those who are eligible. Participation has been decreasing for years. Following state and federal welfare reform, among other policy changes, TANF participation has dropped from 750,000 participants in 1995 to fewer than 80,500 participants.[7] According to the census bureau, more than 776,000 Texas children live in extreme poverty (under 50 percent of the Federal poverty level).[8] Based on current participation levels, Texas has a long way to go to ensure those children are receiving the services we aim to provide.

We believe that any future changes to the TANF program should be budget neutral, in that they do not shift higher costs to other areas of our budget, and that any savings should be re-invested back into the program to ensure a greater utilization level among families living in extreme poverty.

Thank you for your dedication to these important issues. We look forward to our continued productive relationship during the 84th Legislative Session. Count on our continued leadership to ensure that every Texan has access to quality health and human services. May God bless you.

Very truly yours,

Carlos Uresti

Royce West

Judith Zaffirini

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[7] Health and Human Services Commission. *Presentation to Texas Senate Health and Human Services Committee, 2014* [PDF Document]. Retrieved November 18, 2014 from: www.hhsc.state.tx.us/news/presentations/2014/Senate-Presentation-TANF.pdf

[8] Children in Extreme Poverty, number and percent (for states): U.S. Census Bureau. 2013. "2012 American Community Survey 1-Year Estimates," Table B17024. Accessed via American FactFinder 2: http://factfinder2.census.gov. Calculations by the Children's Defense Fund