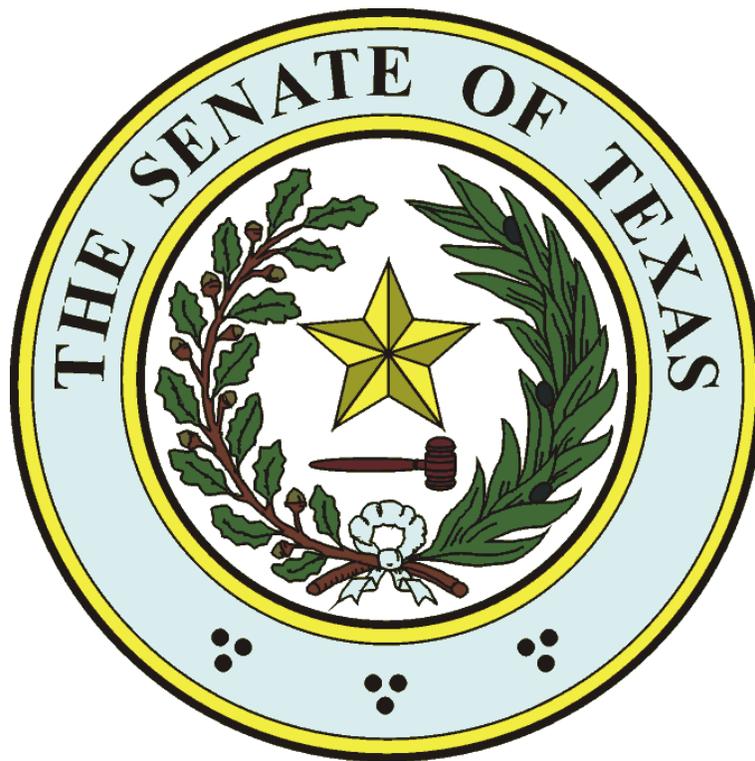


**TEXAS SENATE
COMMITTEE ON HEALTH
AND HUMAN SERVICES**



**INTERIM REPORT
TO THE
83RD LEGISLATURE**

December 2012

Please direct questions or comments to:

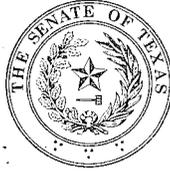
Senator Jane Nelson, Chair

Senate Committee on Health and Human Services
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SENATOR JUDITH ZAFFIRINI

December 6, 2012

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

Dear Governor Dewhurst:

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

This report focuses on identifying efficiencies in the health and human services system to ensure the delivery of quality services while minimizing waste, fraud, and abuse. It includes our review of mental health services, our long-term care system, health care quality initiatives, caseworkers in the Child Protective Services system, and the financing of public health services in Texas.

We appreciate the leadership and foresight you have displayed in asking this Committee to monitor and seek remedies to these key issues, and we trust that the recommendations offered in this report will serve to improve health care and human services in Texas.

Respectfully submitted,



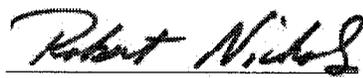
Senator Jane Nelson
Chair



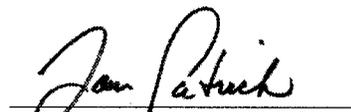
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Vice-Chair



Senator Joan Huffman



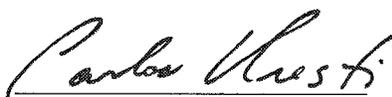
Senator Robert Nichols



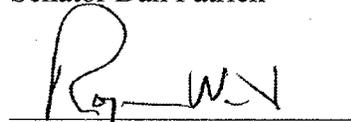
Senator Dan Patrick



Senator Jose Rodriguez



Senator Carlos Uresti



Senator Royce West



Senator Judith Zaffirini

Interim Charges

1. *Federal Health Care Reform* - Monitor the potential impact of the Patient Protection and Affordable Care Act (PPACA) on insurance regulations, Medicaid and Children's Health Insurance Program (CHIP), health care outcomes, health care workforce, overall health of all Texans, and the state budget in Texas. Additionally, monitor the current constitutional challenges to PPACA, and other court cases associated with PPACA, and ensure that the state does not expend any resources until judicial direction is clear. (Joint charge with Senate State Affairs Committee)
2. *Cost Containment Initiatives* - Evaluate the implementation of cost-containment strategies across the Health and Human Services Enterprise to determine if and how each strategy can be expanded upon to achieve additional savings next biennium. The evaluation should include but is not limited to: the expansion of managed care, co-pays in Medicaid, electronic visit verification, and independent assessments for long-term care services. The evaluation should also consider new cost-containment strategies that will increase efficiencies and reduce costs. This evaluation should include but not be limited to: Medicaid, Early Childhood Intervention Services, and immunizations.
3. *Translational Research* - Review the state's current investment in health care innovation, including translational research and the Cancer Prevention Research Institute, which focuses on rapid transfer of new technology experimentation directly into the clinical environment. Make recommendations to improve the health of Texans and encourage continued medical research in the most cost-effective manner possible.
4. *Utilization of Medicaid Services* - Review existing policies for prior authorization and medical necessity review across the Medicaid Program, including nursing homes and orthodontic services. Make recommendations on how these policies could be improved to save money by reducing unnecessary utilization and fraud.
5. *Waiver Efficiencies* - Review the Medicaid Home and Community Based Services Waivers to identify strategies to lower costs, improve quality, and increase access to services. Areas of the review should include, but are not limited to:
 - Functional eligibility determinations to ensure services are only being delivered to individuals that qualify;
 - Financial eligibility determinations to ensure parental income and resources are considered when the client is a minor;
 - Coordination of acute and long-term care services;
 - Development and use of lower-cost community care waiver options;
 - Coordination with the Department of Family and Protective Services (DFPS) for waiver services for children in conservatorships;
 - Reinvesting savings into accessibility of community care for individuals waiting for services.

6. *CPS Caseworkers* - Evaluate the management structure and supervision of CPS caseworkers with an emphasis on rural areas. Identify any legislative changes that could assist DFPS in maximizing efficiency, improving quality casework and supervision, and increasing caseworker retention. Identify any legislative changes that could improve the quality of care children receive while in Child Protective Services custody, including improving permanency outcomes.
7. *Public Health* - Examine the delivery and financing of public health services in our state, including how federal funds are distributed by the state to local health departments and whether the work done by Regional Health Departments operated by the Department of State Health Services overlap unnecessarily with local health departments.
8. *Mental Health* - Review the state's public mental health system and make recommendations to improve access, service utilization, patient outcomes and system efficiencies. Study current service delivery models for outpatient and inpatient care, funding levels, financing methodologies, services provided, and available community-based alternatives to hospitalization. The review should look to other states for best practices or models that may be successful in Texas. The study shall also review and recommend "best value" practices that the state's public mental health system may implement to maximize the use of federal, state, and local funds.
9. Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services and make recommendations for any legislation needed to improve, enhance, and/or complete implementation, including but not limited to:
 - A. *Health Care Quality and Efficiency* – Monitor implementation of initiatives aimed at improving health care quality and efficiency in Texas, including: the transition of Medicaid and the CHIP to quality-based payments, establishment of the Texas Institute of Health Care Quality and Efficiency, implementation of the Health Care Collaborative certificate, patient-centered medical home for high-cost populations, development and use of potentially preventable event outcome measures, and reduction of health care-associated infections. Include recommendations on how to improve and build upon these initiatives, including improving birth outcomes and reducing infant and maternal mortality;
 - B. *Federal Flexibility* – Monitor implementation of initiatives to increase state flexibility, including the Health Care Compact and the Medicaid Demonstration Waiver;
 - C. *Foster Care Redesign* – Monitor implementation of the initiative to redesign the foster care system;
 - D. *State Supported Living Centers* - Implementation of DOJ Settlement agreement to address State Supported Living Center concerns.

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Charge # 1-Federal Health Care Reform: *Monitor the potential impact of the Patient Protection and Affordable Care Act (PPACA) on insurance regulations, Medicaid and Children’s Health Insurance Program (CHIP), health care outcomes, health care workforce, overall health of all Texans, and the state budget in Texas. Additionally, monitor the current constitutional challenges to PPACA, and other court cases associated with PPACA, and ensure that the state does not expend any resources until judicial direction is clear. (Joint charge with Senate State Affairs Committee)*

Section I. Background

In March 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act into law. Taken together, these acts are referred to as the Affordable Care Act (ACA).¹

Texas joined a majority of states in challenging the constitutionality of the ACA. The states’ legal challenge focused on two of the law’s major provisions, the individual mandate and Medicaid expansion.² Beginning in 2014, the individual mandate requires U.S. citizens and legal residents to obtain health insurance coverage or pay a penalty assessed and collected by the federal Internal Revenue Service (IRS). The law allows several exemptions to this requirement, including for financial hardship and religious objections.³ The law also requires state Medicaid programs to expand Medicaid eligibility to 133 percent of the federal poverty level (FPL) in 2014 for individuals under the age of 65, including adults with no dependent children.⁴

On June 28, 2012, after a number of lower court decisions, the U.S. Supreme Court issued its ruling on the ACA. The Supreme Court determined that the individual mandate is a constitutional exercise of Congress’ power to tax. The Court also determined that the Medicaid expansion is constitutional, as long as states not complying with the expansion can continue to receive existing Medicaid funds. While originally a mandatory provision, the Court’s decision on Medicaid expansion rendered the provision voluntary for states.

On August 1, 2012, the Senate Committee on Health and Human Services and the Senate Committee on State Affairs held a joint hearing to receive an update from the Health and Human Services Commission (HHSC) and the Texas Department of Insurance (TDI) on the ACA, including the impact of the Supreme Court’s ruling, implementation activities, and issues facing the 83rd Legislature. The archived video of the hearing can be found online: <http://www.senate.state.tx.us/75r/senate/commit/c610/c610.htm>.

Section II. Analysis

Provisions Relating to the Private Health Insurance Market

Individual Mandate

The Supreme Court upheld the individual mandate as constitutional under Congress’ taxing authority. As such, beginning January 1, 2014, U.S. citizens and legal residents, with certain exemptions, will be required to purchase health insurance coverage or pay a penalty assessed and collected by the IRS. As indicated in Table 1, the penalties more than double each year between 2014 and 2016, and continue to increase based on cost of living in 2017 and beyond.⁵

Table 1 - ACA Penalties

Year	Penalty
2014	\$95 per adult and \$47.50 per child (up to \$285 for a family) or 1% of family income, whichever is greater.
2015	\$325 per adult and \$162.50 per child (up to \$975 for a family) or 2% of family income, whichever is greater.
2016	\$695 per adult and \$347.50 per child (up to \$2,085 for a family) or 2.5% of family income, whichever is greater.
2017 and Beyond	Penalty amount is increased each year by cost of living.

Health Insurance Exchange

One of the major ACA requirements affecting the private health insurance market is the creation of health insurance exchanges in each state by January 1, 2014. The health insurance exchanges will serve as marketplaces where individuals and small businesses will be able to compare health plans, determine whether they are eligible for tax credits or health programs such as Medicaid/CHIP, and purchase health insurance.⁶

States have three options for implementing the health insurance exchange: a state-operated exchange, a state-federal partnership exchange, or a federally facilitated exchange operated by the federal government. States unable to implement, or choosing not to implement, a state-operated or state-federal partnership exchange will have a federally facilitated exchange established for them by the federal government.⁷

The ACA required that states planning to establish a state-operated or state-federal partnership exchange submit a blueprint for their exchange, including a declaration letter signed by the Governor, to the federal Department of Health and Human Services (HHS) by November 16, 2012. Federal HHS has since delayed that deadline until December 14, 2012 for state-operated exchanges and February 15, 2013 for state-federal partnership exchanges.⁸

On July 9, 2012, Governor Rick Perry wrote a letter to HHS Secretary Sebelius providing notice that Texas will not establish an exchange.⁹ Governor Perry sent another letter to Secretary Sebelius on November 15, 2012 reiterating his position. Specific federal guidance on how the federally facilitated exchanges will operate is still pending.

States choosing not to establish a state-operated or state-federal partnership exchange at this time will have the option to transition to one of these exchanges in the future. The state would need to apply for federal funds no later than October 2014 in order to cover the state's start-up costs and submit a transition plan for federal approval one year before the anticipated start date of the state exchange. Because federal funds must be used within three years, the state's transition would need to be completed by 2017.¹⁰ At this time, it is unclear whether the state will choose to transition to a state-based or state-federal partnership exchange in the future; however, the state's

decision to do so could influence legislative and appropriations decisions as early as next session.

Essential Health Benefits

The ACA requires all individual and small group plans inside and outside of the health insurance exchange to cover an “essential health benefits package.” The essential health benefits package must cover ten broad categories of coverage:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance abuse disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services, including oral and vision care.¹¹

To better define the specific services that will be required under these ten broad coverage categories, and any quantitative limits on services, states have the option of selecting a “benchmark plan” (a currently existing health insurance plan) that will act as the minimum standard of coverage for all individual and small group health plans in the state beginning January 1, 2014.¹²

Federal HHS gave states ten benchmark plans to choose from: the three largest small group plans, the three largest state employee health benefit plans, the three largest national federal employee health benefit plans, and the largest commercial non-Medicaid health maintenance organization (HMO).¹³ Table 2 outlines these ten benchmark options in Texas.¹⁴

Table 2 - Texas Essential Health Benefits Benchmark Options

Benchmark Categories	Three Largest Small Group Plans in Texas			Three Largest State Employee Plans in Texas			Three Largest Federal Employee Health Benefit Plans			Largest Non-Medicaid HMO in Texas
	BCBS Best Choice PPO	BCBS Blue Edge HSA	UHC Choice Plus PPO	ERS Health Select	TRS Active Care	UT Select Plan	BCBS Standard Option	BCBS Basic Option	GEHA Standard Option	
Benchmark Plans										Aetna Large Group POS

If a state chooses not to select a benchmark plan, the default benchmark will be the small group plan with the largest enrollment in the state. For Texas, this default plan would be the Blue Cross Blue Shield (BCBS) Best Choice PPO, which provides health insurance coverage to more than 345,000 Texans.¹⁵

At the time of the August 1st hearing, TDI was still in the early stages of analyzing these ten benchmark options to determine which plan best meets the needs of Texans while fulfilling the ACA requirements. There was significant discussion during the hearing about potential costs to the state resulting from existing state health insurance mandates. The concern stemmed from a requirement in the ACA that states pay for any state insurance mandates not covered by the benchmark plan. Since the hearing, TDI has completed further analysis of the benchmark options, and the agency's latest analysis indicates that four of the benchmark options (including the default BCBS Best Choice PPO plan) would not create a cost to the state.¹⁶ However, because federal HHS has yet to provide final guidance to states on submitting a benchmark plan, TDI's analysis is based on its best interpretation of federal guidance available at this time.

States were required to submit a benchmark plan by September 30, 2012; however, in light of missing federal guidance, many states including Texas have not submitted a benchmark plan. It is still unclear when states will receive final guidance.¹⁷

Private Market Provisions Already in Effect

A number of ACA provisions related to private health insurance coverage have already gone into effect and were not impacted by the Supreme Court's ruling. Private market provisions already in effect include:

- Young adult coverage on parents' health insurance plan until age 26;
- Prohibition of lifetime dollar limits on benefits;
- Prohibition against rescinding coverage if policyholder gets sick;
- Prohibition against denying children coverage due to a pre-existing condition;
- Small businesses tax credits to help purchase employee health coverage;
- Pre-Existing Condition Insurance Plan (PCIP) created as a new coverage option for individuals who are uninsured due to a pre-existing condition;
- Health plans required to provide certain preventive services at no cost to the patient; and
- Insurance companies not meeting required minimum medical loss ratios (85 percent for large employer plans and 80 percent for small employer plans) must send rebates to consumers.¹⁸

Provisions Relating to Medicaid

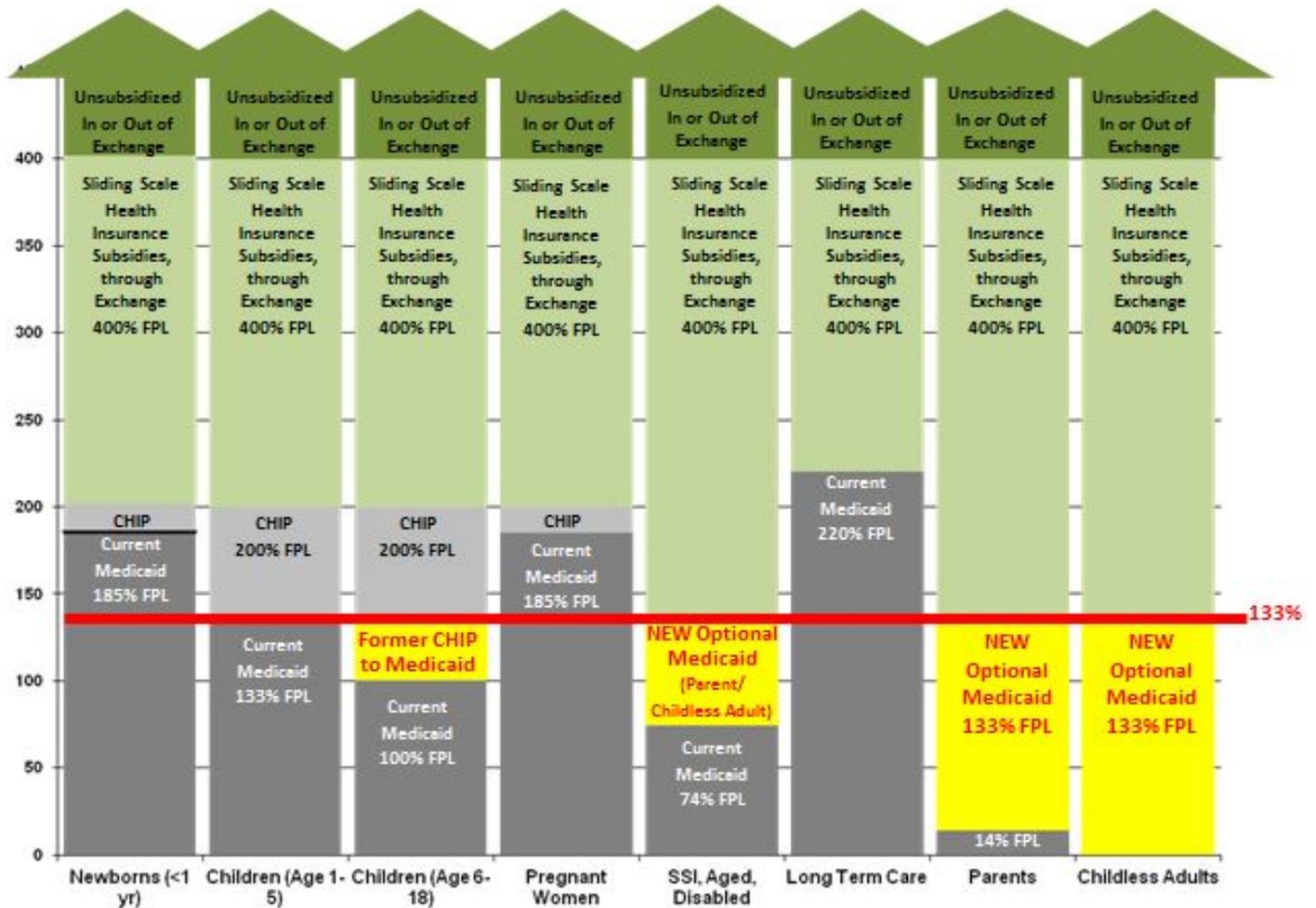
Medicaid Expansion

As a result of the Supreme Court's ruling, Medicaid expansion is now optional for states. At the August 1st hearing, HHSC provided the committees with estimates of the expansion's impact on Medicaid caseload and cost in Texas.

Caseload

The ACA expansion would extend Medicaid coverage to all individuals under age 65, including adults with no dependent children, who have a family income at or below 133 percent FPL and meet citizenship and immigration requirements. The following graph compares current Medicaid income eligibility requirements in Texas with the income requirements under the ACA expansion.¹⁹ Childless adults, currently not covered under the Texas Medicaid program at any income level, would make up the largest expansion group under ACA expansion.

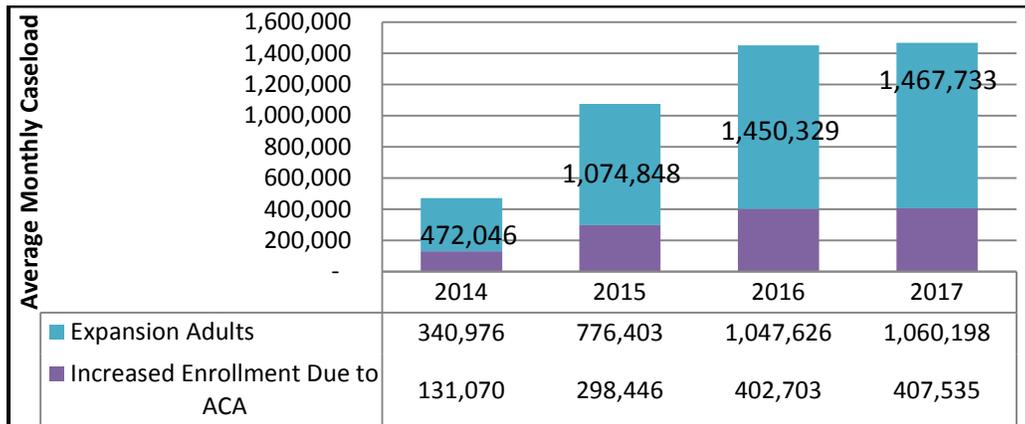
Medicaid Income Eligibility - Current and ACA Expansion



The Texas Medicaid program currently covers approximately 3.5 million individuals. Under Medicaid expansion, HHSC estimates that by 2017, the average monthly caseload of the Medicaid program will increase by nearly 1.5 million individuals. This increase is a combination of the expansion population (1.1 million individuals) and increased enrollment of individuals who are already eligible for Medicaid but not enrolled (400,000 individuals).²⁰ It is believed that this latter group, individuals already eligible but not enrolled, will have increased Medicaid enrollment due to the individual mandate and increased awareness of the Medicaid program as a result of the ACA. This increased enrollment of individuals already eligible for Medicaid (commonly referred to as the Medicaid “take-up” rate) will occur regardless of Medicaid expansion.

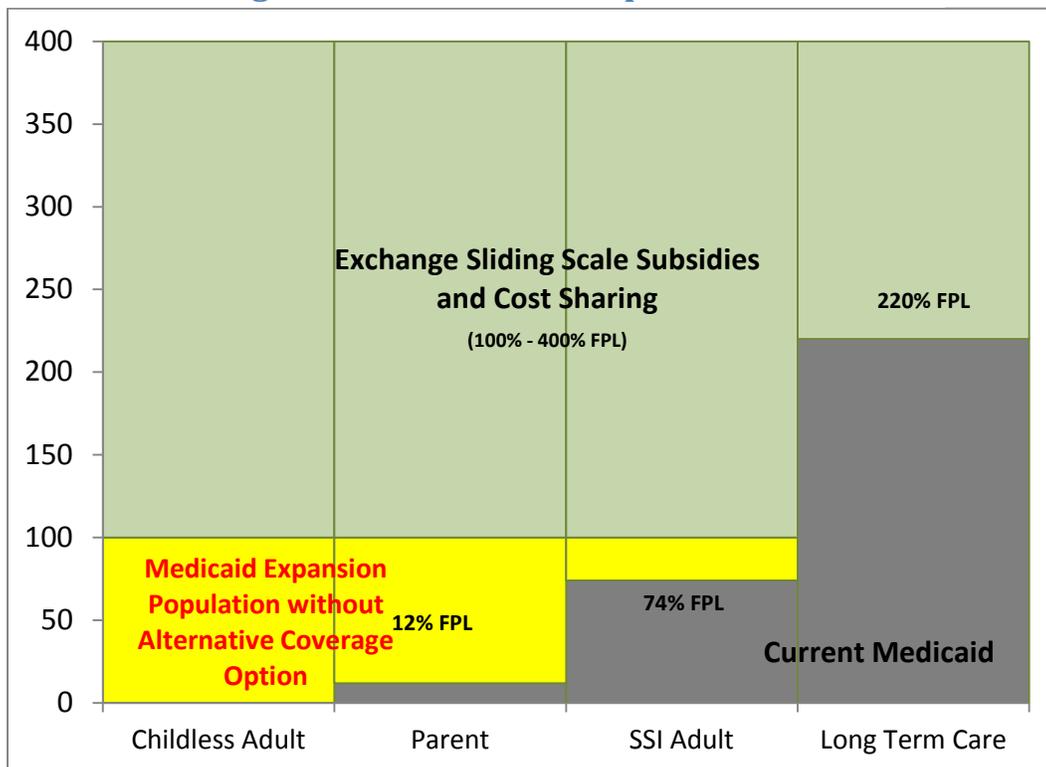
The following graph depicts HHSC’s Medicaid caseload increase estimate due to ACA for calendar years 2014-2017. In addition to the total estimated caseload increase, the graph provides a breakdown between increased enrollment due to the Medicaid expansion and increased enrollment of individuals already eligible under the current Medicaid program (increased “take-up” rate).²¹

Medicaid ACA Caseload Estimates, 2014-2017



As indicated by the graph below, if Texas chooses not to expand Medicaid, adults between 100 and 133 percent of the federal poverty level (FPL) would still be eligible for insurance subsidies through the health insurance exchange. Childless adults between 0 and 100 percent of FPL will not be eligible for Medicaid or insurance subsidies. Texas Medicaid currently covers parents of Medicaid eligible children up to 12 percent of FPL. If the state chooses not to implement the Medicaid expansion, parents between 12 and 100 percent of FPL will not be eligible for Medicaid or subsidies through the exchange.²²

Adult Medicaid Coverage - Current and ACA Expansion

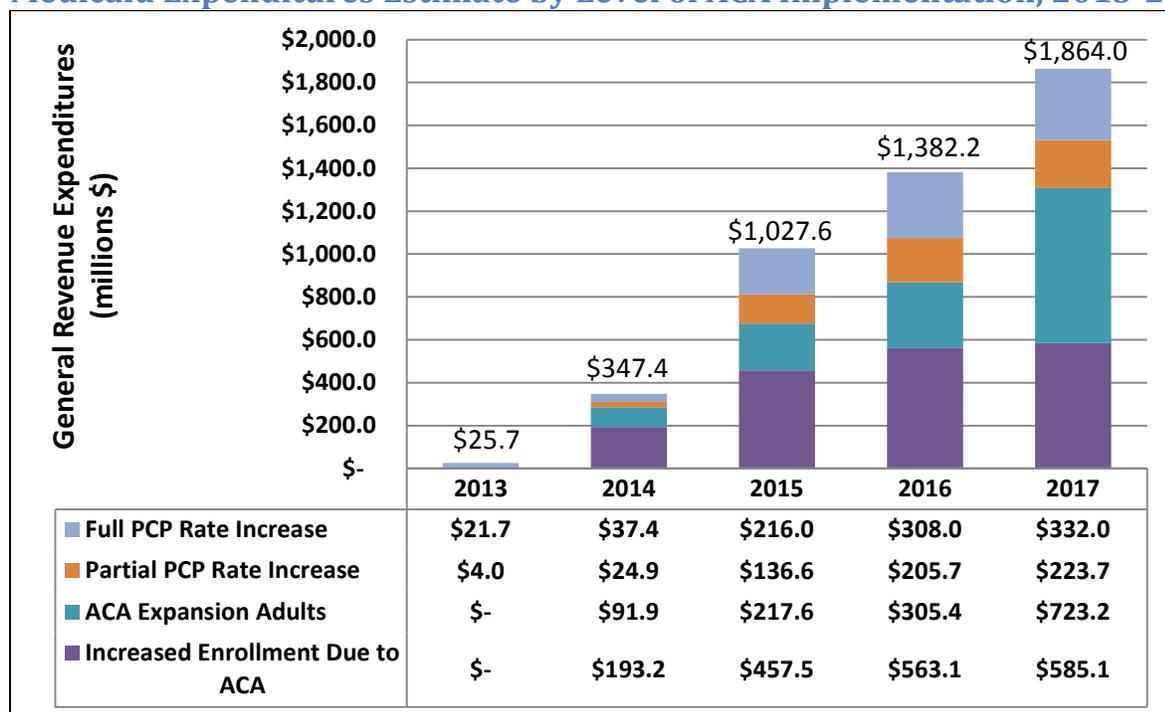


Cost Estimate

At the August joint hearing, HHSC presented the committees with a new estimate for ACA costs related to Medicaid. HHSC estimates that Medicaid-related provisions of the ACA will cost the state approximately \$15 billion in general revenue (GR) over ten years (2014-2023).²³

The following graph reflects HHSC’s cost estimate specifically for years 2013 through 2017.²⁴ This estimate is a combination of administrative costs, increased caseload due to Medicaid expansion and increased take-up rate, and increases in primary care rates. Decreases in federal matching funds, referred to as the federal medical assistance percentage (FMAP), cause significant increases to the state after 2014 for costs associated with the primary care rate changes, and after 2016 for costs associated with the Medicaid expansion population. Administrative costs and primary care rate increases are discussed in further detail below.

Medicaid Expenditures Estimate by Level of ACA Implementation, 2013-2017



Administrative Costs

The state would receive the traditional 50 percent FMAP for administrative costs related to the expansion population. For this reason, HHSC’s estimate includes costs for the expansion population in years 2014-2016 (when there is a 100 percent FMAP for medical services). This estimate assumes an 8 percent across the board administrative cost related to ACA implementation and a 50 percent FMAP for those costs.²⁵

Primary Care Rate Increases

Another cost consideration for the 83rd Legislature will be costs related to increases in Medicaid primary care provider (PCP) rates.

Required Rate Increase (“Partial PCP Increase”): The ACA *requires* states to increase Medicaid rates for *certain primary care providers and services* to the Medicare rate. The rate increase is 100 percent federally funded for calendar years 2013 and 2014; however, states must first increase rates for these services and providers back to the state’s 2009 Medicaid rate (at the regular FMAP) before the federal government will fully fund the required increase to the Medicare rate. HHSC initially estimated that it will cost the state \$4 million GR in 2013 and \$24.9 million GR in 2014 to fund these rates back to 2009 levels for the existing Medicaid eligible population (referred to as “Partial PCP Rate Increase” in graph above). However, final federal rules published on November 1, 2012, may result in an increase to these cost estimates. States are required to implement this rate increase with a January 1, 2013 effective date; however, the State Plan Amendment (SPA) is due to the federal Centers for Medicare and Medicaid Services (CMS) as of March 31, 2013. SPAs submitted by that date, once approved, would be approved retroactively to January 1, 2013.²⁶

Optional Rate Increase (“Full PCP Rate Increase”): HHSC also estimated costs to extend the PCP rate increase beyond what was required under the ACA. This cost estimate includes primary care services delivered by *any Medicaid provider* to existing Medicaid populations and the optional expansion population (assuming 100% FMAP for the optional population). This *optional* increase is referred to as “Full PCP Rate Increase” in the graph above. HHSC initially estimated this increase would cost the state \$21.7 million GR in 2013 and \$37.4 million GR in 2014. However, final federal rules published on November 1, 2012, may result in an increase to these cost estimates.²⁷

State Options Relating to Medicaid Expansion

Rather than accepting or rejecting the Medicaid expansion in its entirety, some states have discussed using the voluntary nature of the expansion to leverage additional federal flexibility for existing and expansion Medicaid populations. Actions by the 83rd Legislature will determine which direction the Texas Medicaid program will take.

Medicaid Provisions Already Implemented

HHSC has already implemented a number of smaller ACA requirements related to the Texas Medicaid program that were not part of the Supreme Court decision:

- Allowing children enrolled in Medicaid and CHIP to elect hospice care without waiving their rights to treatment for their terminal illness;
- Allowing freestanding birthing centers to be eligible for Medicaid reimbursement;
- Claiming federal matching funds for children of school and state employees who are enrolled in CHIP;
- Adding tobacco cessation counseling as a Medicaid benefit for pregnant women;
- Making changes to the drug rebate formulary; and
- Implementing several provisions related to Medicaid program integrity.²⁸

Section III. Conclusion

Instead of providing answers, the Supreme Court's ruling on the ACA, particularly the Medicaid expansion, has created additional questions for states. States also continue to wait for additional federal guidance on provisions with fast approaching implementation deadlines, such as the health insurance exchange and essential health benefits package. As a result, the 83rd Legislature will face a number of challenges and issues related to the ACA when it convenes in January 2013.

¹ Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services and the Senate Committee on State Affairs*, August 1, 2012, p2.

² *Id.*

³ The Henry J. Kaiser Foundation, *A Guide to the Supreme Court's Affordable Care Act Decision*, July 2012, p2.

⁴ *Supra* note 1 at p7.

⁵ The Henry J. Kaiser Foundation, *The Requirement to Buy Coverage Under the Affordable Care Act*, <http://healthreform.kff.org/the-basics/requirement-to-buy-coverage-flowchart.aspx> (Last visited December 2, 2012).

⁶ Congressional Research Services, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act*, August 15, 2012, p2-3.

⁷ The Henry J. Kaiser Foundation, *Establishing Health Insurance Exchanges: An Overview of State Efforts*, November 2012, p1-2.

⁸ *Id.*

⁹ Governor Rick Perry letter to U.S. Department of Health and Human Services Secretary Kathleen Sebelius, July 9, 2012, <http://governor.state.tx.us/files/press-office/O-SebeliusKathleen201207090024.pdf>.

¹⁰ Texas Department of Insurance, *Testimony before the Senate Committee on Health and Human Services and the Senate Committee on State Affairs*, August 1, 2012.

¹¹ *Id.*

¹² *Id.*

¹³ *Id.*

¹⁴ Texas Department of Insurance, *Essential Health Benefits - Analysis of Benchmark Plan Options in Texas by Required PPACA Coverage Categories and State Mandated Benefits and Offers*, September 27, 2012, <http://www.tdi.texas.gov/health/documents/fhrebhanalysis.pdf>.

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ Texas Department of Insurance, *Opportunities for Public Input on Federal Health Reform Issues: Essential Health Benefits*, <http://www.tdi.texas.gov/health/fhrstakeholders.html> (Last visited November 3, 2012).

¹⁸ U.S. Department of Health and Human Services, *What's Changing and When*, <http://www.healthcare.gov/law/timeline/> (Last visited October 14, 2012).

¹⁹ *Supra* note 1 at p8.

²⁰ *Id.* at p12.

²¹ *Id.* at p12-13.

²² *Id.* at p7.

²³ Health and Human Services Commission, *Testimony before the House Appropriations Committee Subcommittee on Article II*, July 12, 2012.

²⁴ *Supra* note 1 at p16.

²⁵ Information received from the Health and Human Services Commission via email September 18, 2012.

²⁶ Information received from the Health and Human Services Commission via email November 20, 2012.

²⁷ *Id.*

²⁸ *Supra* note 1 at p5.

Charge # 2-Cost Containment Initiatives: *Evaluate the implementation of cost-containment strategies across the Health and Human Services Enterprise to determine if and how each strategy can be expanded upon to achieve additional savings next biennium. The evaluation should include but is not limited to: the expansion of managed care, co-pays in Medicaid, electronic visit verification, and independent assessments for long-term care services. The evaluation should also consider new cost-containment strategies that will increase efficiencies and reduce costs. This evaluation should include but not be limited to: Medicaid, Early Childhood Intervention Services, and immunizations.*

Section I: Background

During the 82nd Legislative Session, the Chair of the Senate Finance Committee appointed the Subcommittee on Medicaid to identify cost-containment strategies in Medicaid and across the Health and Human Services (HHS) Enterprise. Throughout Session, the Subcommittee held numerous hearings to identify potential savings across the system, prioritizing savings resulting from efficiencies, improvements to quality, and enhanced coordination. As a result, the Subcommittee identified nearly \$3 billion in savings to General Revenue (GR) for Fiscal Years (FY) 2012-13 without impacting the number of individuals eligible for Medicaid or significantly impacting Medicaid benefits.

Based on revisions to the original estimates, the HHS Enterprise will achieve approximately \$2.4 billion in savings.¹ Additionally, the Subcommittee's initiatives lowered cost trends in Medicaid by five percent during FY 2012-13 and six percent during FY 2013 alone, the first year of full implementation. These lower cost trends are expected to produce savings in the next biennium as well.²

In a continued effort to contain costs and ensure an efficient use of taxpayer dollars, the 83rd Legislature should explore the potential to expand upon the efforts underway in the current biennium, as well as identify additional opportunities for a more efficient and less costly health care system.

Section II: Analysis

Part 1 - Cost Containment: FY 2012-13

The \$3 billion in cost-containment strategies were located throughout HB 1; however, a majority of the savings were included in the following budget riders:

HHSC Rider 51

In order to better coordinate care and provide greater efficiencies within the Medicaid program, the 82nd Legislature directed HHSC to enact several major expansions of managed care:

- STAR and STAR+PLUS expansion to counties adjacent to existing managed care services areas;
- STAR+PLUS expansion to El Paso and Lubbock;
- STAR+PLUS and STAR expansion to the Hidalgo Service Area;
- STAR expansion to the Medicaid Rural Service Area;

- Carve-in of prescription drug benefits;
- Dental managed care model for Medicaid; and
- Carve-in of inpatient hospital services in STAR+PLUS.

The STAR and STAR+PLUS expansion to adjacent counties went into effect on September 1, 2011, while the remaining expansions went into effect March 1, 2012.³

HB 1 assumed that the six managed care expansions would result in \$385.6 million in state GR savings and \$238.0 million in increased premium tax revenue. However, due to external factors related to the original estimates, HHSC now estimates it will achieve \$263.3 million in GR savings and \$200 million in increased premium tax revenue for FY 2012-13.

External Factors

- Newer Caseload Data: Caseload assumptions have decreased since the time of HHSC's original savings estimate. The estimate is calculated based on savings "per member per month," so a decrease in the number of members decreases total cost savings.
- Impact of Other Cost Containment Initiatives: The cost savings estimate assumed in HB 1 was developed before other cost containment initiatives were known. The impact of other cost containment initiatives has reduced the "per member per month" cost. As with caseload, the impact of decreased "per member per month" costs reduces the amount of total cost savings attributable to managed care expansion.

HHSC Rider 61

Rider 61 identified \$450 million in GR savings through 30 cost containment initiatives aimed at improving quality of care and health outcomes. HHSC estimates that it will achieve 80% of the cost containment target or \$360.1 million in GR.⁴

Rider 61 Initiatives⁵

1. Implement payment reform and quality based payments in fee for service and managed care.
2. Increasing neonatal intensive care management.
3. Transitioning outpatient Medicaid payments to a fee schedule.
4. Developing more appropriate emergency department hospital rates for nonemergency related visits.
5. Maximizing co-payments in all Medicaid and non-Medicaid programs.
6. Maximizing federal matching funds through a combination of a Medicaid waiver, full-risk transportation broker pilots, and/or inclusion of transportation services in managed care organizations.
7. Reducing costs for durable medical equipment and laboratory services through rate reductions, utilization management and consolidation.
8. Statewide monitoring of community care through telephony in Medicaid fee-for-service and managed care.
9. Expanding billing coordination to all non-Medicaid programs.

10. Increasing utilization of over-the-counter medicines.
11. Renegotiating more efficient contracts.
12. Equalizing the prescription drug benefit statewide.
13. Allowing group billing for up to three children at one time in a foster care or home setting who receive private duty nursing services.
14. Achieving more competitive drug ingredient pricing.
15. Increasing generic prescription drug utilization.
16. Improving birth outcomes by reducing birth trauma and elective inductions.
17. Increasing competition and incentivizing quality outcomes through a statewide Standard Dollar Amount and applying an administrative cap.
18. Establishing a capitated rate to cover wrap-around services for individuals enrolled in a Medicare Advantage Plan.
19. Improving care coordination for Children with Disabilities in managed care.
20. Automatically enrolling clients into managed care plans.
21. Restricting payment of out-of-state services to the Medicaid rate and only our border regions.
22. Increasing utilization management for provider-administered drugs.
23. Implementing the Medicare billing prohibition.
24. Increasing the assessment timeline for private duty nursing.
25. Maximizing federal match for services currently paid for with 100 percent general revenue.
26. Adjusting amount, scope and duration for services.
27. Increasing fraud, waste and abuse detection and claims.
28. Strengthening prior authorization when efficient.
29. Paying more appropriately for outliers.
30. Additional initiatives identified by the Health and Human Services Commission.

HHSC Rider 80 - DME

Rider 80 identified \$88 million in savings to general revenue from changes to durable medical equipment policies, including:

- Targeted rate reductions;
- Selective contracting for incontinence supplies; and
- Adding Diabetic supplies as a category on the pharmacy preferred drug list.

HHSC estimates that it will achieve \$84.9 million in savings, or 96% of the cost containment target.

Special Provisions, Section 16

The Subcommittee worked to minimize provider rate reductions. Ultimately, rates were reduced as indicated in Tables 1 and 2. These reductions were estimated to achieve \$571.3 million in savings to GR. Using current estimates, HHSC will achieve \$486.6 million in savings, or 85% of the cost containment target.⁶

Table 1⁷

	FY 2011	2012-13 Biennium
Department of Aging and Disability Services		
1. Community Care Entitlement	0%	0%
2. Home and Community-based Services (HCS)	-2%	-1%
3. Other Community Care Waivers	0%	0%
4. PACE	0%	0%
5. Nursing Facilities	-3%	0%
6. Medicare Copay Skilled Nursing Facility	0%	0%
7. Nursing Facility-related Hospice	-1%	-2%
8. Intermediate Care Facilities- MR, excluding state supported living centers	-3%	-2%

Table 2⁸

	FY 2011	2012-13 Biennium
Health and Human Services Commission		
1. CHIP Physicians	-2%	0%
2. CHIP Dental Providers	-2%	0%
3. Other CHIP Providers	-2%	-8%
4. Medicaid Physician Services	-2%	0%
5. Medicaid Hospital Services, excluding those reimbursed under TEFRA	-2%	-8%
6. Medicaid Dental and Orthodontic Services	-2%	0%
7. Medicaid Durable Medical Equipment	-2%	-10.5%
8. Medicaid Laboratory Services, excluding reimbursements to the Department of State Health Services	-2%	-10.5%
9. Medicaid Pediatric Private Duty Nursing and Home Health	-2%	0%
10. Other Medicaid Providers	-2%	-5%

Special Provisions, Section 17

Section 17 identified \$705 million in GR savings through 14 cost containment initiatives across multiple HHSC Enterprise agencies, as indicated in Table 3. HHSC estimates that it will achieve \$577.5 million in GR savings, or 82%.⁹

Table 3

<p>Department of Aging and Disability Services</p> <ul style="list-style-type: none">• Nursing facility cost change• Wrap around services• Equalizing rates across waivers• Adjust amount, scope and duration for all community services• Administrative reductions related to requisition <p>Department of State Health Services</p> <ul style="list-style-type: none">• Residential Units• NorthSTAR billing change• Medicines at discharge for one week• Management changes <p>Health and Human Services Commission</p> <ul style="list-style-type: none">• Fee reductions for vendor drug dispensing fee and primary care case management fee• Optional benefit reduction through changes in amount, scope, and duration of services• Medicare equalization• Reduce managed care administrative portion of premiums• More efficient managed care premium methodology

HHSC Rider 59 - Federal Flexibility

HHSC was directed to achieve \$700 million in savings to GR by containing cost growth in Medicaid and CHIP (Children's Health Insurance Program) by seeking federal approval for a waiver to permit the following:

- Greater flexibility in standards and levels of eligibility in Medicaid and CHIP programs;
- Design and implement benefit packages that target the specific health needs and reflect the geographic and demographic needs of Texas;
- Foster a culture of individual responsibility through the appropriate use of co-payments;
- Consolidate funding streams to increase accountability, transparency, and efficiency;
- Federal government responsibility for 100% of the health care services provided to unauthorized immigrants; and
- Expenditures, both state and local, be utilized to maximize federal matching funds.

Several other legislative initiatives overlap with the goals of Rider 59. These include the Medicaid Reform Waiver and the Medicaid Transformation Waiver, both authorized by Senate Bill 7 (82R, 1st Called, by Nelson). The Medicaid Reform Waiver Legislative Oversight Committee recently published its report, which is available online: [URL](http://www.hhsc.state.tx.us/1115-waiver.shtml). Implementation efforts related to the Medicaid Transformation Waiver are currently underway. More information about the Medicaid Transformation Waiver and current implementation activities is available online: <http://www.hhsc.state.tx.us/1115-waiver.shtml>.

Because the Medicaid Reform Waiver is still in development, savings will not be realized until a later date. However, there were savings attributable to an increase in federal funds per a recalculation in the FMAP, or the rate used to determine the federal portion of total Medicaid costs for a state (see below).

Federal Medical Assistance Percentages (FMAP) Increase

Prior to 82nd Legislative Session, there were concerns raised regarding the inequity of funds Texas received from the federal government for Medicaid compared to the amount Texas provided to the federal government in tax receipts. Specifically, Texas received 6.8% of federal Medicaid funds but provided 8.4% of federal tax receipts resulting in an estimated \$3.2 billion net outflow of dollars from Texas to pay for other states' Medicaid programs.¹⁰ The "federal flexibility" rider 59 was discussed as a means for HHSC to work with the federal government for greater flexibility and to potentially change the FMAP formula to address the inequity.

Although HHSC was unable to change the actual FMAP formula, the state did experience \$441.8 million in GR savings due to a revised FMAP. Because HHSC budgets on a biennial basis, HHSC had to forecast the FMAP for FY 2013. The actual FMAP for FY 2013 was higher than the estimated rate, resulting in a savings to the state of \$441.8 million GR.

Part 2 - Cost Containment: Fiscal Years 14-15

As Medicaid and health care costs continue to grow, the state must continue to expand upon past efforts to contain costs and identify new strategies for additional savings. The initiatives should continue to be prioritized in a manner that achieves savings through efficiencies, improvements to quality, and enhanced coordination.

Managed Care

The 82nd Legislature significantly expanded the use of managed care as discussed above. However, there are still areas of the state and specific populations that are excluded from the managed care system.

Implementing managed care statewide produces savings and enhances client services by:

- Establishing a medical home for Medicaid clients through a primary care provider;
- Emphasizing preventative care;
- Improving access to care including serving some clients previously on waiting list for long-term care support services;
- Ensuring appropriate utilization of services;
- Improving health outcomes and quality of care; and
- Enhancing client and provider satisfaction.¹¹

Because managed care provides savings *and* improves the quality of care, the state should continue to look for ways to expand managed care for all client types across the entire state.

Opportunities for managed care expansions include:

- Expand STAR+PLUS statewide by including the Medicaid Rural Service Area;

- Carve nursing facility services into STAR+PLUS;
- Carve the Medically Dependent Children Program (MDCP) into managed care;
- Require managed care enrollment for all Medicaid populations in managed care service areas;
- Use managed care strategies to better coordinate care for individuals with intellectual and developmental disabilities;
- Carve medical transportation services into managed care; and
- Carve mental health services for targeted case management and rehabilitation services into managed care.

Improve Birth Outcomes

In Texas, 13.2% of births are preterm, compared to 12% nationwide. Babies born preterm often have a low birth weight and are underdeveloped, placing these babies at a greater risk for adverse health outcomes, including death. Additionally, the average cost for a normal delivery is \$2,500, compared to \$45,000 for an infant who is admitted to the neonatal intensive care unit (NICU).¹² HHSC has estimated that a 1% reduction in NICU utilization results in \$3.1 million in savings to general revenue.

In an effort to reduce preterm births and improve birth outcomes, the Legislature has already taken the following actions:

- Discontinued Medicaid payments for non-medically necessary delivery prior to 39 weeks;
- Appropriated \$4.1 million for Healthy Texas Babies for FY 2012-13 to fund local initiatives aimed at reducing factors that are known to cause unhealthy birth outcomes (e.g., poor pre-pregnancy health, lack of prenatal care, smoking, poor nutrition, and preterm elective induction before 39 weeks); and
- Increased NICU management according to Rider 61 as described above.

To build upon these efforts, the Legislature should explore the following initiatives for FY 2014-15:

- Equalize Medicaid reimbursement for C-sections and normal deliveries and reinvest part of the savings to reward providers with better birth outcomes such as lower C-section rates, lower NICU utilization, and lower potentially preventable complications;
- Adjust reimbursements to MCOs to reward positive, and penalize negative, birth outcomes;
- Create a pilot to bundle payments to providers for prenatal care, labor, and delivery;
- Improve access to information so that MCOs can better identify mothers at risk for preterm birth and contractually require the MCOs to contact and manage the care of these clients within a specified amount of time after they enroll in the MCO's plan; and
- Fast track Medicaid enrollment and eligibility for mothers that have had a previous preterm birth in Medicaid to ensure they are receiving appropriate prenatal care as soon as possible.

Appropriate Utilization

The Medicaid system must have an adequate process in place to ensure recipients only receive the appropriate level of services. Preventing overutilization both increases savings and improves outcomes.

Currently, the Medicaid program uses a combination of prior authorization (prior to service delivery) and utilization review (post service delivery) to ensure recipients are only receiving the services truly needed. In spite of these current processes, there are still reports of significant overutilization across the Medicaid program and particularly within orthodontics, medical transportation, and nursing facilities.

The HHSC enterprise must strengthen prior authorization requirements, ensure those requirements are appropriately implemented, expand utilization review, and work with MCOs to implement similar protections in managed care.

For more information about appropriate utilization, see Charge 4.

Long Term Care

In FY 2010, the Medicaid aged, blind, and disabled (ABD) population comprised only 25% of the Medicaid caseload, but represented 58% of Medicaid costs.

To improve coordination between acute and long term care, improve outcomes within the long term care system and reduce costs, the Legislature should explore the following initiatives for FY 2014-15:

- Develop quality-based outcome measures and payment systems for the Medicaid long-term care services and supports system, including nursing facilities and home and community based services waivers;
- Carve nursing facility services into managed care; and
- Use managed care strategies to better coordinate care for individuals with intellectual and developmental disabilities and children with disabilities (see Charge 5 for more information).

Quality Based Payments

Over the last few Sessions, the Legislature made significant efforts to transition the way Medicaid services are reimbursed, shifting the focus from quantity of services delivered to quality of outcomes. While this is a complex undertaking, HHSC should work to ensure that initiatives already required by the Legislature are fully implemented. In addition to existing initiatives, the Legislature should continue to reform the Medicaid payment system to incentivize quality outcomes and efficient use of state resources. For example, the Legislature should consider including quality outcomes as a "add-on" to the hospital reimbursement formula known as the SDA, or standard dollar amount.

Additionally, Charge 9a explores opportunities for continuing the transition to an outcome based payment system.

Fraud, Waste and Abuse

Medicaid accounts for a significant and growing portion of the state budget and provides critical services to qualifying individuals. The state can ill afford to lose funds to fraudulent activity and must maintain a robust process to actively prevent, detect, and investigate fraud, waste, and abuse across the Medicaid program.

Specifically, HHSC should take steps to analyze data across the Medicaid program to identify anomalies, outliers, or red flags that could indicate fraud, waste, or abuse. This review process will ensure the state is proactively working to detect potential fraud, waste, and abuse before it escalates, thereby minimizing the impact.

Additionally, the Legislature should explore the following initiatives for FY 2014-15:

- Strengthen state policies relating to marketing to Medicaid clients by providers;
- Review and strengthen agency policies related to ambulance providers;
- Permanently exclude a provider from the Texas Medicaid program who has been excluded or debarred from a state or federal health care program for fraud, or for injury to a child, senior, or individual with a disability;
- Validate that the Office of the Inspector General's responsibility to prevent, detect, audit, inspect, review, and investigate fraud, waste, and abuse extends across all health and human services programs; and
- Clarify that "another adult" authorized by a parent or legal guardian to accompany a child to a Medicaid visit or screening cannot be the provider of services.

Personal Responsibility

The Legislature has required cost sharing within Medicaid that encourages personal accountability and appropriate utilization of health care services, including cost sharing for recipients who receive non-emergency medical services through a hospital emergency department.¹³ HHSC is currently in the process of requesting flexibility from CMS to implement this copayment requirement for non-emergency use of the emergency room.

The Legislature should continue to explore options to encourage personal responsibility including copayments for prescription drugs and a missed appointment fee.

Additional Initiatives

There are several initiatives the Legislature intended to be implemented during FY 2012-13; however, they have yet to be implemented. HHSC should ensure that any remaining cost containment initiatives required by the 82nd Legislature are fully implemented.

In addition to the cost containment initiatives already discussed, the Legislature should explore the following cost-containment opportunities:

- Continue reductions in emergency department rates for non-emergency services;
- Review and adjust all Medicaid rates that are currently higher than the Medicare rate;
- Develop a more appropriate fee schedule for therapy services; and
- Expand electronic visit verification in Medicaid across the state, including in managed care.

Section III: Conclusion

The 83rd Legislature must continue to contain costs and ensure an efficient use of taxpayer dollars by identifying potential savings across the health care system by prioritizing strategies that promote efficiencies, improvements to quality, and enhanced coordination of services.

¹ This estimate includes the cost savings estimate included in Health and Human Services Commission Legislative Appropriations Request for FY 2014-2015 and the increase in appropriations due to an increase in the FMAP rate.

² Health and Human Services Commission, *Medicaid Managed Care Expansion Savings Fiscal Years 2012-2013*, Report Required by House Bill 1, Article II, Health and Human Services Commission, Rider 51, 82nd Regular Session, 2011 (Pitts/Ogden); July 2012.

³ Health and Human Services Commission, *Medicaid Managed Care Initiatives*, <http://www.hhsc.state.tx.us/medicaid/MMC.shtml>. Accessed November 14, 2012.

⁴ Health and Human Services Commission, *Legislative Appropriations Request Fiscal Years 2014-2015*.

⁵ House Bill 1, Article II, Health and Human Services Commission, Rider 61, 82nd Regular Session, 2011. (Pitts/Ogden)

⁶ *Supra* note 4.

⁷ House Bill 1, Article II, Health and Human Services Commission, Special Provisions Section 16, 82nd Regular Session, 2011. (Pitts/Ogden)

⁸ *Id.*

⁹ *Supra* note 4.

¹⁰ Health and Human Services Commission, *Impact on Texas if Medicaid is Eliminated: Report on House Bill 497, 81st Regular Session*, December 2010, p 29, Appendix F.

¹¹ *Supra* note 2.

¹² Health and Human Services Commission, *Press Release: Medicaid Initiative Seeks to Reduce Risk of Premature Births*, July 3, 2012.

¹³ Senate Bill 7, Section 1.09, 82nd Regular Session, 2011 (Nelson/Zerwas).

Charge #3- Translational Research: *Review the state's current investment in health care innovation, including translational research and the Cancer Prevention Research Institute, which focuses on rapid transfer of new technology experimentation directly into the clinical environment. Make recommendations to improve the health of Texans and encourage continued medical research in the most cost-effective manner possible.*

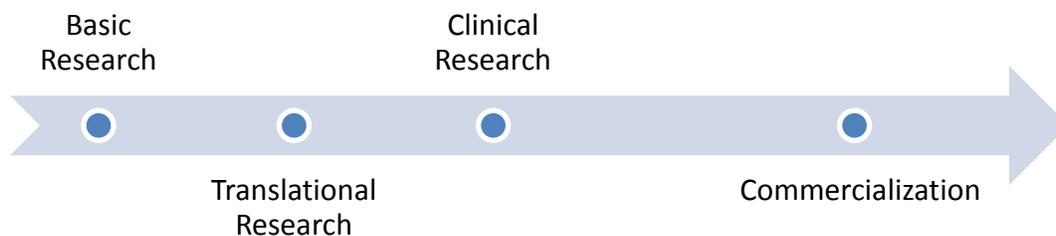
Section I: Background

Healthcare innovation is advanced through medical research, which evolves in three general stages: basic, translational, and clinical research. While basic research focuses on the acquisition of knowledge without an obligation to apply it to practical ends, translational and clinical research move discoveries made in the basic research stage towards actual treatments and cures for patients.

- *Translational research* takes basic research findings and applies them to the prevention or treatment of a specific disease or medical issue. During the translational phase, research activities begin to focus specifically on developing drugs, devices and diagnostics.
- *Clinical research* is the patient-oriented final stage of medical research in which clinical trials take place.¹

Once the clinical phase of research is completed, the process by which clinical findings are translated into actual treatments available to patients is known as commercialization. Although commercialization is an extremely crucial part of the pipeline through which basic scientific discoveries become actual treatments for patients, this report will focus on the level of translational and clinical research currently taking place in the state and how to increase collaboration among the entities conducting these types of research.

Figure 1. Medical Research Pipeline



The pipeline through which medical research moves from basic research to actual patient treatments is time-consuming and extremely costly. Along the way, very few basic research discoveries fully develop into patient treatments, while the rest fall into what is known as the

'death valley' of medical innovation, or the gap between basic research discoveries and viable medical treatments.² Increasing translational and clinical research and the rate at which discoveries can be translated into viable treatments will improve the lives of Texans and move the state's medical researchers closer to cures for devastating diseases such as cancer.

Extensive translational and clinical medical research is taking place at a variety of entities throughout the state with support from various funding sources. In order to expedite the process by which research discoveries are translated into viable treatments and cures for patients, the state must explore ways to maximize funding for these efforts and foster collaborations among these institutions to promote best practices, improve efficiency, and maximize the use of our research dollars so that our investment saves lives and improves the overall health of Texans.

Section II: Analysis

Current Level of Translational Medical Research

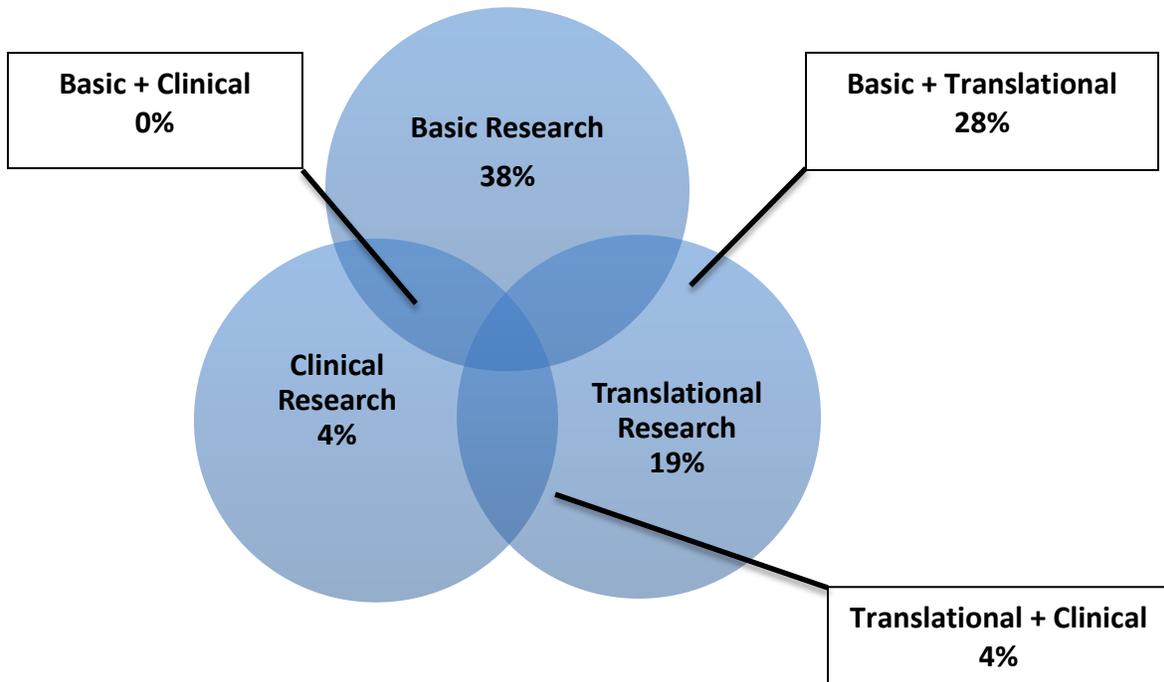
In Texas, translational and clinical medical research is supported through a variety of state-sponsored and non-state-sponsored entities.

State-sponsored entities:

The Cancer Prevention and Research Institute (CPRIT): CPRIT was established by the Texas Legislature in 2007 and approved by voters through Proposition 15, a constitutional amendment which authorized \$3 billion in general obligation bonds over a 10 year period. CPRIT focuses on expediting innovative cancer research and commercialization of cancer treatments, as well as enhancing access to evidence-based prevention programs and services throughout the state.³

Utilizing expert, out-of state peer reviewers and an Oversight Committee, CPRIT awards grants for all stages of cancer research, invests in companies developing drugs and devices to treat cancer, and funds prevention activities throughout the state. To date, CPRIT has awarded 427 grants totaling \$756 million. 309 of these grants, totaling \$572 million, have funded research projects. 62% of these projects have included some translational or clinical research, and 27% have focused exclusively on translational or clinical research.⁴ The breakdown of CPRIT grants that have supported basic, translational, and clinical research is shown in figure 1.

Figure 1. Breakdown of CPRIT Research Awards



Recognizing that CPRIT operates with public dollars, the Legislature structured the Institute to ensure that the peer review process is free of bias and that the awarding of grants is based on the best science. The Legislature also enacted provisions designed to prevent conflicts of interest among Oversight Committee members and peer reviewers.⁵ In light of the importance of the funding entrusted to CPRIT by taxpayers and the promise of these funds to deliver treatments for patients, the Institute should continue to ensure a rigorous peer review process, enforce robust conflict of interest protections, and strive to ensure transparency in their grant-making process in keeping with the objectives established by the Legislature and the voters of Texas via Proposition 15.

Although CPRIT grants are awarded based on the best science as determined by peer reviewers, the Institute also has a statutory duty to fund research that could lead to medical and scientific breakthroughs in the search for a cure for cancer, such as translational research. Since July 2011, CPRIT has attempted to increase the Institute's focus on translational research by creating three new grant programs:

- Texas Life Sciences Incubator Award: Supports the development or enhancement of incubator organizations that will provide valuable programs and services to enhance the ability to commercialize innovative products for the diagnosis, treatment, or prevention of cancer and to establish infrastructure that is critical to the development of a robust life sciences industry in the state.
- Early Translational Research Award: Supports projects that bridge the gap between promising new discoveries achieved in the research laboratory and commercial development of diagnostics, drugs and devices.
- Recruitment of Investigators Performing Translational Research: Supports the recruitment of investigators performing translational cancer research.

The degree to which CPRIT continues to focus on translational research in the future will be partially determined by the Institute's Future Directions Initiative, which utilizes a workgroup of CPRIT's advisory committee members to solicit input from stakeholders across the state on how to best prioritize grant resources moving forward. The workgroup will also conduct a thorough examination of CPRIT's review and award processes.

Emerging Technology Fund. The Emerging Technology Fund (ETF) was created by the Texas Legislature in 2005 with the goal of fostering a more robust high-technology sector in the state.⁶ Since its inception, the ETF has awarded over \$259 million to recruit translational and clinical researchers to Texas, support commercialization efforts, and secure matching grant funding from external sources. \$220 million of ETF's \$259 million in funding has been invested in biotechnology and life sciences sector, which has been used to support translational and clinical research and the recruitment of translational and clinical medical investigators in the biotechnology and life sciences industry. This investment has led to the creation of over 1,500 jobs and attracted close to \$1 billion in additional funding from the federal government, the private sector, and other sources.⁷

State-sponsored institutions of higher education: All of Texas' nine state-sponsored health related institutions conduct translational and clinical medical research. Using funding from the National Institutes of Health (NIH) Clinical and Translational Science Awards (CTSA) Program as well as state funding, six of these entities have established centers within their institutions to focus exclusively on the advancement of clinical and translational sciences. The NIH CTSA Program seeks to expand national capacity for clinical and translational medical research by funding the establishment of a network of clinical and translational research centers at academic health-related institutions throughout the country, known as the CTSA Consortium.⁸ Two additional state-sponsored health related institutions have partnered with CTSA Award recipients to participate in these centers.⁹

One of Texas' state-sponsored health-related institutions, the M.D. Anderson Cancer Center, has also recently established the Institute for Applied Cancer Science (IACS). The IACS focuses on accelerating the delivery of new, safe and highly effective therapeutics for cancer patients and seeks to radically improve cancer survivor rates within the next ten years by more effectively integrating disease biology and drug discovery. The Institute uses attributes of both the academic and industrial research fields to more quickly identify and validate new cancer targets

and convert that scientific knowledge into clinical trails that will lead to the development of new cancer drugs.¹⁰

Non-state sponsored entities: Non-state entities such as private health-related institutions are also engaged in translational and clinical medical research. One example is the Texas Methodist Hospital Research Institute (TMHRI), which was founded in 2004 as the research arm of the Methodist Hospital System. TMHRI seeks to rapidly and efficiently translate medical discoveries made in the laboratory and the clinic into new diagnostics, therapies, and treatments. The Institute uses interdisciplinary teams of scientists to conduct research and clinical trials in the fields of cancer, cardiovascular disease, inflammation, diabetes, infectious disease, neuroscience, transplantation biology, genomic medicine, tissue engineering, and regenerative medicine. Discoveries by TMHRI's researchers have led to over 700 clinical trials in the Institute's eight year history.¹¹

Funding

Funding for translational and clinical research at Texas entities comes from state, federal, and other sources.

State Funding: Although there is no mechanism to capture the full level of state investment in clinical and translational research, the state has made a significant investment in advancing medical translational and clinical research by:

- Providing extensive funding for general medical research at our nine state-sponsored institutions of higher education;
- Providing approximately \$215 million in matching funds through state-sponsored health related institutions for CTSA Awards;
- Awarding \$177 million in CPRIT funding to support translational and clinical research¹²; and
- Awarding \$220 million in ETF funding to support biotechnology and life sciences research.

Federal Funding: The NIH has provided funding to Texas entities for translational and clinical research through the CTSA Program and other grants and awards. Through the CTSA Program, the NIH has awarded \$131 million to national CTSA Consortium members in Texas.¹³ The entities who have received these awards are eligible to receive additional NIH funding to support their translational and clinical research efforts through award renewals after the initial five year award term expires. One entity has already been awarded a renewed contract and is currently in its second five year funding cycle, while another is currently competing for a renewal contract. In addition to funding for state-sponsored entities in the CTSA Consortium, the NIH has also awarded funding to the TMHRI to support its translational and clinic research efforts. Beyond NIH funding, state investments in clinical and translational research have successfully attracted additional federal funding to Texas research entities through various grants and other funding streams.

Other Funding Sources: State investments in translational and clinical research have helped to attract other forms of funding to the state for these purposes. For example, much of the \$1 billion in follow-up funding that has resulted from the state's \$220 million ETF investment in biotechnology and life sciences has come from private sector investments.¹⁴ Additionally, CPRIT awards to companies that are working to develop and market life-saving cancer drugs and diagnostics have resulted in royalties and equity payments to the state.

Collaboration

Despite extensive funding for translational and clinical medical research at institutions throughout the state, more collaboration among these entities is needed to leverage existing resources.

Current collaborations: Four of the state's health-related institutions of higher education that serve as members of the national CTSA Consortium have formed the Texas Clinical and Translational Science Award Consortium, including the University of Texas Health Science Center at Houston, the University of Texas Health Science Center at San Antonio, the University of Texas Medical Branch at Galveston, and the University of Texas Southwestern Medical Center in Dallas.¹⁵ So far, this consortium has funded research projects by more than 2,000 researchers across more than 100 biomedical fields, has trained 60 students and 82 research assistants to conduct and assist with translational and clinical research, and has led to more than 3,000 scientific and medical publications.¹⁶

Increasing collaboration: In order to increase collaboration among entities in the state that are performing translational and clinical research, a Task Force of representatives of these entities could be formed in order to:

- Determine the level of existing infrastructure in the state that may foster collaboration on clinical and translational research;
- Summarize existing state efforts to attract advanced clinical and translational researchers to the state;
- Summarize efforts to draw investments to the state to advance clinical and translational research and translate medical discoveries into commercialized medical treatments; and
- Make recommendations on how the state should:
 - Leverage existing resources and infrastructure to increase collaboration and encourage more investment in translational and clinical research;
 - Coordinate existing efforts between members of the Texas CTSA Consortium and other entities in the state engaged in translational and clinical research; and
 - More effectively recruit translational and clinical researchers.

Section III: Conclusion

In order to expedite the process by which basic medical discoveries are translated into effective medical treatments for patients, the state must increase the level of translational and clinical research conducted in the state and the level of collaboration among researchers and research

entities. This can be accomplished in part by utilizing the extensive state, federal, and private resources that are already being dedicated to translational and clinical research.

Section IV: Recommendation

Establish a Task Force to assess the state's current efforts and capacity to promote translational and clinical research and make recommendations on how to leverage existing resources and infrastructure to encourage more investment in this type of research and better coordinate existing efforts.

¹ Bill Gimson, Cancer Prevention and Research Institute, Testimony before the Senate Committee on Health and Human Services, July 31, 2012.

² Dr. Mauro Ferrari, Texas Methodist Hospital Research Institute, Testimony before the Senate Committee on Health and Human Services, July 31, 2012.

³ House Bill 14, 80th Regular Session, 2007 (Keffer/Nelson); House Joint Resolution 90, 80th Regular Session, 2007 (Keffer/Nelson).

⁴ Information provided by Cancer Prevention and Research Institute via email, November 12, 2012.

⁵ *Supra* note 3 and House Bill 1358, 81st Regular Session, 2009 (Keffer/Nelson).

⁶ House Bill 1765, 79th Regular Session, 2005 (Morrison/Shapiro)

⁷ Laurie M. Rich, Texas Emerging Technology Fund, Testimony before the Senate Committee on Health and Human Services, July 31, 2012.

⁸ Dr. Patricia Hurn, University of Texas System, Testimony before the Senate Committee on Health and Human Services, July 31, 2012.

⁹ National Institutes of Health, Clinical and Translational Science Award website, Accessible at <https://www.ctsacentral.org/>.

¹⁰ Dr. Giulio Draetta, M.D. Anderson Cancer Center Institute for Applied Cancer Science, *Testimony before the Senate Committee on Health and Human Services*, July 31, 2012.

¹¹ *Supra* note 2 at p.2.

¹² *Supra* note 4.

¹³ *Supra* note 8 at p.5.

¹⁴ *Supra* note 7 at p. 3.

¹⁵ *Supra* note 8 at p.4.

¹⁶ *Supra* note 8.

Charge #4- Utilization of Medicaid Services: *Review existing policies for prior authorization and medical necessity review across the Medicaid Program, including nursing homes and orthodontic services. Make recommendations on how these policies could be improved to save money by reducing unnecessary utilization and fraud.*

Section I. Background

Medicaid is a jointly funded state-federal health care program that primarily serves low-income children, pregnant women, seniors, and individuals of any age with disabilities.

Medicaid provides acute care health services such as visits with physicians and other health care providers; inpatient and outpatient hospital services; and pharmacy, lab and x-ray services. Medicaid also provides a broad range of long-term care services and supports for older individuals and individuals of any age with physical, intellectual, and/or developmental disabilities such as nursing facility care, community-based services, and services provided in intermediate care facilities for individuals with an intellectual disability or related conditions (ICF/IIDs).¹ States are required to provide "medically necessary" care to all eligible individuals who seek services.²

Recent findings of unnecessary utilization and fraud in the Medicaid orthodontics, nursing facility, and medical transportation programs have raised concerns about the processes used by the Health and Human Services Commission (HHSC), the Department of Aging and Disability Services (DADS), and their contractors to determine medical necessity for Medicaid services. This report includes a broad analysis of medical necessity determination across the Medicaid program and more specific discussions regarding the orthodontics, nursing facility, and medical transportation programs.

On March 20, 2012, the Senate Committee on Health and Human Services held a public hearing on Charge 4. The Committee received presentations from HHSC, DADS, the Office of the Attorney General (OAG), Office of the Inspector General (OIG), and the Texas State Board of Dental Examiners (TSBDE). An archived video of the hearing is available online: <http://www.senate.state.tx.us/avarchive/?yr=2012>.

Section II. Analysis

The process for determining medical necessity for Medicaid services varies significantly between acute care services and long-term services and supports (LTSS).

Medicaid Acute Care Services

According to HHSC, medically necessary services are "activities that may be justified as reasonable, necessary, and/or appropriate, based on state Medicaid policies." Prior authorization (PA) is a process by which providers obtain approval for a service prior to initiating the service. It is an important tool used to determine whether a service is justified as medically necessary for a particular Medicaid client, and some Medicaid services require PA as a condition for reimbursement.³ PA is not unique to Medicaid; it is also widely used by health insurers in the private market to ensure appropriate utilization of services and reduce fraud.

For Medicaid acute care, the process and entity responsible for prior authorization of services depends on whether the services are provided through the traditional fee-for-service delivery system or managed care.

Fee-for-Service

To determine which Medicaid acute care services require PA under fee-for-service, HHSC utilizes a comprehensive medical and dental policy review and development process governed by the Benefits Management Workgroup (BMW). The BMW is composed of clinical and policy staff from HHSC and other enterprise agencies, and clinical staff from the Texas Medical Foundation and Texas Medicaid and Healthcare Partnership (TMHP).⁴

The workgroup takes a number of factors into account to determine which services should require prior authorization, including whether a service is costly, at high risk for fraud, or typically required to have prior authorization in the private health insurance market. Each prior authorization costs the state approximately \$30, so the workgroup also determines whether the benefits of requiring prior authorization for a particular service outweighs the cost.⁵ The workgroup is also responsible for determining the criteria that must be met (e.g., client age, diagnosis) and documentation a provider must submit with the prior authorization request.⁶

As a result of the BMW review process, a number of Medicaid acute care services currently require PA under fee-for-service. These services include, but are not limited to:

- Non-emergency ambulance transports;
- Durable medical equipment;
- CT/MRI imaging procedures;
- Physical, occupational, and speech therapy;
- Transplants;
- Private duty nursing;
- Inpatient psychiatric admissions;
- Oxygen and respiratory equipment; and
- Therapeutic dental services and orthodontics (includes crowns, braces, and other services not provided in routine checkups).⁷

Prior authorizations for these services are performed by the Texas Medicaid and Healthcare Partnership (TMHP), the state's Medicaid Claims Administrator. Under TMHP's prior authorization process:

1. A provider submits a complete prior authorization request to TMHP with all required documentation.
2. TMHP determines if the request meets current medical necessity criteria.
3. Once the review is complete, the provider and client are both notified of the outcome.⁸

In determining whether a prior authorization request meets medical necessity criteria, TMHP is contractually required by HHSC to follow all state and federal laws and policies, including policies determined by the BMW. The top ten prior authorized Medicaid services (based on services provided between March 1, 2011 and September 1, 2011) are listed below by frequency (Table 1) and by cost (Table 2).⁹ Of note, the most frequently authorized medical service during

this time period was orthodontic visits. Medicaid orthodontia is discussed in more detail later in this report.

Table 1 - Ten Most Frequently Prior Authorized Medicaid Services (3/1/11-9/1/11)

Authorization Services	Frequency
Orthodontic Visits	56,594
Physical and Occupational Therapy	24,685
Speech Therapy	23,798
Non-emergency Ambulance	15,911
Obstetric Ultrasounds	13,648
Skin Sealant, Protectant, Moisturizer	7,783
Bath/Shower Chair	5,801
Home Health Skilled Nursing Visit	5,652
MRI Brain with or without dye	5,393
MRI Lumbar Spine without dye	5,087

Table 2 - Ten Most Costly Prior Authorized Medicaid Services (3/1/11-9/1/11)

Authorization Services	Cost
Private Duty Nursing	\$194.6 million
Speech Therapy	\$139.7 million
Physical and Occupational Therapy	\$110.5 million
Inpatient Hospital Accommodation	\$88.2 million
Personal Care Services	\$57.0 million
Orthodontic Visits	\$54.2 million
Inpatient Psychiatric Hospital Accommodation	\$37.4 million
Residential Detoxification	\$24.5 million
Non-emergency Ambulance	\$19.4 million
Hearing Aids	\$16.8 million

Managed Care

PA for services provided under managed care are conducted by the various contracted managed care organizations (MCOs) throughout the state, not TMHP.¹⁰ MCOs are required to provide the base scope of benefits available under the Medicaid program; however, each MCO has flexibility to determine what restrictions or limitations to place on those benefits, including requiring PA. Unlike the fee-for-service PA process described earlier, HHSC does not *require* the MCOs to perform PA on specific services; however, MCOs are contractually required to ensure that all services provided through its plan meet the state’s medical necessity criteria.¹¹ Because of the nature of capitated payments under managed care, MCOs are also financially motivated to ensure appropriate utilization of services and reduce overutilization.

The 82nd Texas Legislature (2011) directed HHSC to implement several major Medicaid managed care expansions, including:

- STAR and STAR+PLUS expansion to counties adjacent to existing managed care services areas;
- STAR+PLUS expansion to El Paso and Lubbock;
- STAR+PLUS and STAR expansion to the Hidalgo Service Area;
- STAR expansion to the Medicaid Rural Service Area;
- Carve-in of prescription drug benefits;
- Dental managed care model for Medicaid; and
- Carve-in of inpatient hospital services in STAR+PLUS.

The STAR and STAR+PLUS expansion to adjacent counties went into effect on September 1, 2011, while the remaining expansions went into effect March 1, 2012.¹²

Because more Medicaid services are now delivered through managed care, MCOs will be responsible for a significantly higher percentage of prior authorizations, while TMHP will be responsible for less.

Acute Care Examples

This section analyzes examples of over-utilization recently identified in Medicaid orthodontia, the Medicaid Transportation Program (MTP), and non-emergency transportation provided by ambulance providers, and provides recommendations for addressing concerns highlighted by these programs.

Medicaid Orthodontia

In 2011, the Texas Medicaid program made local and national headlines for its utilization of orthodontia services. From 2008 to 2010, Medicaid expenditures for orthodontia services increased from \$102 million to \$185 million.¹³ Medicaid expenditures for orthodontia services in Texas for that period surpassed orthodontia expenditures in all other states combined.¹⁴

Texas Medicaid policy does not allow orthodontia for cosmetic reasons. State Medicaid policy limits orthodontic services (including braces) to the treatment of medically necessary cases for:

- Children ages 13 and older with severe handicapping malocclusion (a misalignment of teeth that causes the upper and lower teeth not to fit together correctly); and
- Children ages birth through 20 with cleft palate or other special medically necessary circumstances.¹⁵

Additionally, providers are required to obtain prior authorization for orthodontia services. Given that orthodontia under the Texas Medicaid program is limited to the treatment of these specific medically necessary cases and requires prior authorization, the significant increase in utilization, especially as compared to other states, was indicative of major weaknesses in the prior authorization process.

Issues Identified

"Rubber Stamping" Requests

Following reports of overutilization, HHSC reviewed TMHP's prior authorization process for orthodontia and identified several areas where improvement was necessary.¹⁶ The most concerning finding was that many of TMHP's medical necessity determinations were not performed by a dentist or orthodontist, as required under state law. Instead, TMHP "dental specialists" (not dentists or orthodontists) were approving prior authorization requests without sending the request to a TMHP dentist or orthodontist. The result was "rubber stamp" approvals of PA requests.¹⁷

Both the federal and state OIG are auditing the TMHP prior authorization process to determine if TMHP-approved services met the state criteria. The audits are also determining whether PA requests were fraudulently submitted by providers.¹⁸ Depending on the results of these audits, the state should seek recoupment from TMHP and providers whose actions resulted in inappropriate utilization and costs to the Medicaid program.

Inadequate Contract Monitoring

HHSC's contract monitoring process for TMHP focused on metrics such as timeliness, which does not indicate whether an authorization was conducted correctly. This was a major reason HHSC did not realize that TMHP was incorrectly approving orthodontia requests. Additionally, HHSC was not auditing TMHP-approved prior authorizations to ensure that the authorizations were being done accurately and in compliance with state law and policies.¹⁹

Inaccurate Assumptions about Cost Growth

In addition to weaknesses in the agency's contract monitoring and auditing processes, there was an inaccurate assumption by HHSC that the increased utilization of orthodontia services was the result of efforts to increase access to preventive dental care under the *Frew* settlement. Although *Frew* did not address orthodontia services directly, it was assumed that the increase in preventive dental checkups was leading to an increase in identification of children who needed orthodontia services.²⁰

Fee-for-Service Reimbursement

The Texas Medicaid fee-for-service orthodontia reimbursement policy created a perverse incentive for providers to see patients more frequently than necessary in order to bill Medicaid. The average number of visits for a child receiving orthodontia services is typically 12 visits a year. Children receiving orthodontia services under Texas Medicaid averaged 22 visits a year.²¹

Marketing of Medicaid Clients

Shortly after concerns of orthodontia overutilization were raised, reports about the illegal solicitation of Medicaid clients by dental providers began to surface. Examples included dental providers hiring recruiters to solicit parents to bring their Medicaid-eligible children to their clinic in exchange for gifts (e.g., iPods, tickets to the zoo, electronic toothbrushes) and offering free transportation to receive services.

Standard of Care Concerns

In addition to the financial impact of orthodontia overutilization, concerns have been raised about the impact of overutilization on patient care and safety. Reports have emerged of egregious practices such as children unnecessarily being strapped down during treatment and providers refusing to allow parents to accompany their child during treatment. Such reports are attributed to an emphasis on profits rather than quality care and focus on large chain dental clinics. These clinics are believed to be under the corporate influence of dental service organizations (DSOs), businesses that are intended to provide only non-clinical services to dental practices. Concerns have been raised that some DSOs are exerting influence on dentists by setting treatment quotas and making decisions impacting clinical services. This influence has the potential to increase unnecessary services and reduce quality of care.

According to the TSBDE, which is responsible for regulating the practice of dentistry in Texas, the board only has legal authority to take action against a license holder. Because the board does not currently regulate DSOs, the board is unable to take any disciplinary action against a DSO believed to be illegally influencing the practice of dentistry.²²

Improvements Already Implemented

In response to concerns about orthodontia utilization, the 82nd Legislature included a rider in the Appropriations Act requiring HHSC to conduct more extensive reviews of medical necessity for orthodontia services and to strengthen the OIG's capacity to detect, investigate, and prosecute abuse by dentists and orthodontists.²³ In response to this legislative direction and internal reviews by the agency, HHSC has initiated a number of policy changes to improve the prior authorization process for Medicaid orthodontia.

Staffing Changes

In response to HHSC's findings, TMHP has made staffing changes. In September 2011, TMHP terminated the former dental director. TMHP hired a new dental director as well as four orthodontists and additional staff within the dental prior authorization unit.²⁴ HHSC has also hired a full-time Medicaid/CHIP dental director.²⁵

Strengthening Prior Authorization Requirements

HHSC made several immediate changes to its fee-for-service orthodontia policies:

- Effective October 1, 2011, HHSC began requiring dentists to submit full-cast dental molds with all orthodontia requests. This is in addition to the radiographs, photos, and other documentation already required.²⁶
- HHSC increased the minimum age for orthodontia treatment (except in special circumstances like cleft palate) from 12 to 13.²⁷
- HHSC has limited who can provide Medicaid orthodontic services to board certified and board-eligible orthodontists.²⁸

Strengthening Contract Monitoring

HHSC has revised its contract monitoring process to include additional measures such as staff qualifications, volume (i.e. is it even possible for one person to approve the volume of requests), and accuracy. HHSC is also now auditing a random sample of TMHP's authorizations each

quarter to ensure that authorizations are being done accurately and in compliance with state law and policies.²⁹

Managed Care Expansion

The inclusion of dental benefits into managed care has likely had the most significant impact on addressing overutilization in Medicaid orthodontia. Certain features of the dental maintenance organizations (DMOs) are expected to reduce unnecessary utilization. For example, DMOs monitor for unusual trends in service delivery. Also, each DMO has a Special Investigative Unit to track, trend, and report possible fraud, waste, and abuse.³⁰ The OIG is also conducting comprehensive audits of the Medicaid MCOs, including the DMOs.

Opportunities for Improvement

As discussed above, HHSC has implemented a number of changes aimed at improving the prior authorization process for orthodontia. Additionally, the OIG is working to complete its audit of the program and identify state overpayments. HHSC and OIG should continue current efforts to prevent overutilization and fraud within Medicaid orthodontia services and expand those efforts through the additional opportunities detailed below.

Comprehensive Payments for Orthodontia

HHSC is in the process of developing comprehensive payments for orthodontia services that will discontinue the state's previous policy of paying for each visit separately, which helped contribute to overutilization.³¹ This should remove the incentive for providers to see patients more frequently than necessary.

Strengthen Prohibitions against Marketing

The transition of dental benefits to managed care was expected to reduce the ability of providers to illegally solicit Medicaid clients because clients are now required to have a “dental home.” However, concerns regarding the solicitation of Medicaid patients have continued. HHSC and OIG should ensure that all Medicaid providers, including those contracting with MCOs, are not illegally soliciting Medicaid clients.

Continue to Monitor DMOs

According to HHSC, prior authorizations for orthodontic services have already significantly reduced under managed care.³² HHSC and OIG should continue to monitor the prior authorization process of DMOs to ensure that prior authorizations are being done in accordance with state medical necessity criteria.

Improving Patient Protection and Safety

In order to address concerns that some DSOs are influencing dental treatment, DSOs should be required, at a minimum, to register with the TSBDE. The Legislature should also consider funding for TSBDE before adding additional regulatory responsibilities. TSBDE's Legislative Appropriations Request for FY 2014-2015 included a request for additional staff to keep up with the board's current workload.

Additionally, regardless of whether a child is covered by Medicaid or private health insurance, dentists should be required to give parents the option of accompanying their child into the treatment room.

Medical Transportation Program

The Medical Transportation Program (MTP) is a federally-required service that arranges non-emergency medical transportation to health services appointments for Medicaid clients who do not have other means of transportation. In 2011, MTP served approximately 350,000 Medicaid clients through approximately 9 million trips. Earlier this year, HHSC requested an internal audit of MTP and found a number of problems with the program.³³ Additionally, reports have surfaced that some Medicaid providers have not complied with existing requirements regarding parental accompaniment of children receiving MTP services.

Issues Identified

Increased Use of Advance Funds

One of the most concerning findings of the MTP audit was the drastic increase in the use of advance funds. Advance funds are cash provided to clients to pay for transportation prior to the medical service being delivered. Between 2008 and 2011, the use of advance funds increased from \$19 million to \$53 million.³⁴ Advance funds is unique to MTP. The state does not advance funds in any other Medicaid program. There are a number of alternatives to advance funds. For example, rather than advancing funds, the state can pay directly for a hotel or transportation. Nothing in state or federal law requires states to allow advance funds in MTP.³⁵

Lack of Verification of Services

The MTP audit found that HHSC did not have an adequate process in place to prevent payments for transportation when no health care service was actually rendered, or to ensure that MTP was not paying multiple times for the same trip. In conjunction with the increase in advance funds use, this was a particularly concerning finding.

Inadequate Contract Monitoring

Like orthodontia, there were deficiencies within HHSC's contract monitoring of its MTP vendors. Transportation providers were not always fully monitored based on the level of risk to the program.³⁶ The MTP audit also found issues with HHSC's advance funds contractor. The advance funds contractor was reimbursed a flat fee (\$11) for each transaction. The MTP audit found that in some cases, rather than bundling a series of advance funds, the advance funds contractor charged a separate fee for each, resulting in a greater cost to the state.³⁷

Transport of Children without Parents

In March 2012, HHSC became aware that some Medicaid therapy providers were transporting children without their parents or a legal guardian to receive services. HHSC sent a letter to therapy and MTP providers reminding them of existing state requirements that:

- 1) children be accompanied by a parent or legal guardian when receiving MTP services; and
- 2) children be accompanied by a parent, legal guardian, or another adult authorized by the child's parent or legal guardian to visits and screenings under the Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

To circumvent these requirements, providers were acting as the authorized adult for both MTP services and EPSDT visits and screenings. Following HHSC's letter, therapy providers sought, and obtained, a temporary restraining order (TRO) prohibiting HHSC from being able to enforce these requirements. HHSC has issued an appeal and the TRO has been lifted; therefore, HHSC is currently enforcing these policies. Additionally, HHSC is allowing parents to authorize another adult to accompany a child for MTP services; however, providers are still prohibited from acting as the authorized adult for both EPSDT and MTP.³⁸

Improvements Already Implemented

Change to Advance Funds Policy

Effective June 1st, 2012, HHSC revised its advance funds policy to increase accountability and to impose stricter fiscal controls.³⁹

Verification of Services

On March 1, 2012, the processing of MTP claims was transferred to TMHP.⁴⁰ Now that TMHP processes both medical and MTP claims, TMHP is able to verify whether each MTP service actually has a corresponding medical visit.

Improved Contract Monitoring

In response to the audit findings, HHSC is implementing several corrective actions including a risk-based process to more closely audit transportation providers that pose a greater risk (e.g., past provider performance, contract value).⁴¹ Additionally, the advance funds contract was terminated on August 1, 2012 and HHSC has assumed management of requests and distribution of funds.⁴²

Opportunities for Improvement

HHSC and OIG should continue efforts to prevent overutilization and fraud within MTP. There are also several additional opportunities the state can pursue.

Verifying Need for Services

MTP is intended to provide transportation to clients who do not have any other means of transportation. Currently, the need for MTP services is completely self-declared by the client and there is no confirmation by HHSC that the client has no other transportation. HHSC should develop methods for verifying whether a client truly has no other means of transportation.

Managed Care

The 82nd Legislature directed HHSC to transition the entire state MTP program into either the full-risk broker (FRB) model or into managed care.⁴³ HHSC is currently piloting the FRB model and has not yet implemented either model statewide.

While both the managed care and FRB models provide budget certainty through capitated payments, each model has advantages the other does not. For example, the FRB model can serve both managed care clients and clients who still receive medical services through fee-for-service, while the managed care model allows transportation and health care services to be linked, ensuring that transportation services are being used for actual medical appointments.

The state must choose one model for statewide implementation. In October and November of 2012, HHSC held stakeholder meetings across the state to solicit stakeholder input on these two models and any others that may exist.⁴⁴ Executive Commissioner Janek is expected to issue a recommendation to the 83rd Legislature on a statewide MTP model based on feedback received in these stakeholder meetings.

Validating State Policies

State law already places limitations on who can accompany a child when receiving MTP services and EPSDT visits and screenings. However, to ensure that providers are not the only adult present when a child is receiving these services, the Legislature should validate that the intent of current state policies is to ensure that a *provider* is not serving as "another adult" authorized by the child's parent.

Non-Emergency Ambulance Services

To receive non-emergency transportation services under Medicaid, a physician must complete a medical necessity form, verifying that the Medicaid client requires the service.

As of the Committee's March hearing, the OAG had 69 open investigations on ambulance providers that were providing transportation to Medicaid clients that did not qualify for ambulance transport.⁴⁵ Examples of ambulance fraud include the forging of physician signatures on medical necessity forms by ambulance providers and physicians signing the medical necessity form when the service is not actually necessary.

HHSC should review the laws and policies related to the use of non-emergent ambulance services in Medicaid to determine if any changes are needed to ensure that ambulances are only used when medically necessary and that the state is not paying for ambulance services that have been denied for payment by Medicare. Likewise, the Department of State Health Services (DSHS), which regulates ambulance providers, and the Texas Medical Board (TMB), which regulates physicians, should review their respective agency policies relating to the provision of non-emergency ambulance services to reduce the incidence of fraud, waste, and abuse.

Medicaid Long-Term Services and Supports

To qualify for Medicaid LTSS, an individual must meet both financial and functional eligibility criteria. Functional eligibility is based on an individual's need for services resulting from physical, intellectual, or developmental disabilities and varies across different LTSS programs and services.⁴⁶ For an overview of Medicaid LTSS entitlement programs and home and community-based services (HCBS) waiver programs, see Charge 5.

Nursing Facility Program

To qualify for nursing facility services, a physician must certify that an individual has a need for daily or regular skilled nursing.⁴⁷ Specifically, the individual must demonstrate a medical condition that is of sufficient seriousness that the individual's needs exceed the routine care which may be given by an untrained person, and requires supervision, assessment, planning, and intervention by licensed nurses that are available only in an institution.⁴⁸

The medical necessity determination process for a nursing facility begins when a registered nurse at a nursing facility completes the Minimum Data Set (MDS) assessment on an individual. An MDS assessment must be completed initially at admission to the nursing facility, every 92 days thereafter, and upon any significant change in the resident's condition.⁴⁹ The MDS assessment identifies an individual's functional capabilities and health programs, and includes information about the individual's:

- hearing, speech, and vision;
- mental status;
- mood;
- behavior;
- functional status;
- bladder and bowel continence;
- active diagnosis;
- health conditions;
- swallowing/nutritional status;
- skin conditions;
- medications; and
- special treatments, procedures, and programs.

The completed MDS is reviewed by an automated system at TMHP. Certain conditions, such as a ventilator or feeding tube, will automatically qualify an individual for nursing facility care.⁵⁰ If the MDS does not include enough information for the automated system to make a determination, the assessment is reviewed manually by a TMHP registered nurse.⁵¹

In addition to determining whether an individual qualifies for nursing facility care, the MDS assessment also determines the nursing facility's daily reimbursement rate for providing care to that individual.⁵²

Once an individual has spent at least 184 days in a nursing facility, regardless of whether the individual's condition improves in the future, permanent medical necessity is established. This policy was established to prevent individuals being discharged from a nursing facility and not having a home to return to.⁵³ Approximately 46,000 of the 56,000 individuals living in nursing facilities have established permanent medical necessity.⁵⁴

Issues Identified

Conflict of Interest

Because the nursing facility (provider of services) is also completing the MDS assessment, which is used to determine nursing facility admission and reimbursement rate, there is an inherent conflict of interest in the nursing facility medical necessity determination process.

The automated system used by TMHP approves medical necessity for nursing facility care based on information entered in the MDS assessment by the nursing facility. Because the automated system only checks to make sure certain condition codes are present (e.g., ventilator, feeding tube), there is potential for fraud.

Hospital Discharge and Planning

Texas has a high percentage of individuals residing in nursing facilities with light care needs. There may be potential for these individuals to be better served in the community; however, this will require improvements in the hospital discharge and planning process.⁵⁵

Opportunities for Improvement

Strengthen Contract Monitoring

DADS monitors TMHP's performance in regards to nursing facility determinations through self-reported data produced by TMHP.⁵⁶ DADS is improving this process by having DADS staff, not TMHP staff, perform retrospective reviews of manual medical necessity determinations by TMHP nurses.⁵⁷ However, these reviews do not address the accuracy of determinations made through TMHP's automated system. DADS should develop a process by which TMHP's automated medical necessity determinations are also retrospectively reviewed for accuracy.

Carve Nursing Facility Services into STAR+PLUS

The primary concern with the nursing facility medical determination process is that the nursing facility completes the medical necessity assessment and provides the services. Carving nursing facility services into STAR+PLUS may help alleviate conflicts of interest currently in the medical necessity process. In conjunction with carving inpatient hospital services into STAR+PLUS last legislative session, the STAR+PLUS managed care organizations (MCOs) will have greater ability, responsibility, and incentives to coordinate care between nursing facilities, hospitals, and other acute care services. For example, by improving the hospital discharge and planning process, the MCO could help an individual stay in the community, rather than move into a more expensive nursing facility.

OIG Medical Necessity Reviews

The OIG conducts a review of nursing facilities to assess the accuracy of reimbursement (the daily reimbursement rate is determined using the MDS filled out by the nursing facility). OIG has approximately 76 nurse and administrative staff performing these reviews.⁵⁸

In May 2011, concerns about the nursing facility medical determination process were raised after media reports surfaced alleging that residents at a Texas nursing facility were seen riding bikes and lifting weights. These reports led to an investigation into the nursing facility by DADS and OIG. At the time, no agency was auditing whether individuals residing in nursing facilities actually met the medical necessity criteria.

In February 2012, OIG began conducting medical necessity reviews, in addition to its reimbursement reviews, to determine whether individuals in nursing facilities qualify for nursing facility care.⁵⁹ Between February and August 2012, OIG reviewed medical necessity at 118 nursing facilities, reviewed 632 residents in those facilities, and reviewed 1,818 forms prepared by the nursing facilities. OIG found 15 residents not meeting medical necessity requirements. The state recoupment value for these 15 residents is \$153,492 for the time period reviewed.⁶⁰ The OIG should continue and expand its medical necessity reviews in nursing facilities.

Home and Community-Based Services Waivers

Like nursing facilities, individuals applying for Medicaid home and community-based services (HCBS) waiver programs must meet specified functional eligibility criteria. DADS uses a process called "utilization review" to ensure that services are being authorized appropriately. Charge 5 includes a detailed discussion about functional eligibility for the HCBS waivers and utilization review.

Overarching Findings/Recommendations

In its review of the medical necessity determination process and analyses of several specific utilization issues, the Committee has identified overarching concerns that must be addressed to reduce unnecessary utilization of services across the entire Medicaid program:

- inadequate monitoring and quality assurance of vendors contracted by HHSC;
- overutilization because outliers were either not noticed or incorrectly justified; and
- conflicts of interest within the medical necessity determination process, particularly for LTSS.

In response to these overarching concerns, there are several opportunities for improving the system:

Increase Quality Assurance Processes

HHSC does not audit TMHP's prior authorization determinations comprehensively. For example, HHSC did not previously audit TMHP's orthodontia prior authorizations to ensure that medical necessity policies were being consistently applied. In response to the recent overutilization of orthodontia services, HHSC is now auditing samples of TMHP's orthodontia prior authorizations. However, rather than wait until a problem is discovered, the Committee believes HHSC and DADS should review the entire Medicaid program to determine if there are areas of prior authorization and medical necessity determination that need quality assurance processes to ensure that services are being authorized appropriately.

Avoid Tendency to Attribute Increases to Frew

Because the objective of the Frew settlement was to increase the number of children who receive medical and dental checkups and other medically necessary services, there has been a tendency within the Texas Medicaid program to attribute increases in service utilization by children to the *Frew* settlement. However, this tendency can cause unnecessary utilization and fraud to continue unnoticed as it did with orthodontia overutilization. HHSC and OIG should thoroughly examine the reasons behind utilization patterns and avoid the assumption that increases in utilization are the result of Frew. Additionally, HHSC should establish data analytical processes to improve contract management; detect data trends; and identify anomalies in service utilization, payment methodologies, and adherence to requirements in Medicaid and CHIP managed care and fee-for-service contracts.

Address Remaining Conflict of Interest

For some LTSS programs, the provider of services also determines medical necessity and provides case management, creating a conflict of interest and potential incentive for overutilization of services. HHSC and DADS should address remaining conflict of interest within the medical necessity determination process.

Expand Interagency Efforts

Interagency Coordination

HHSC, OAG, and OIG all play key roles in combating fraud, waste, and abuse in the Medicaid and other HHS programs. Because each agency interfaces with the Medicaid program for different purposes, coordination between these agencies is critical to enable the program to respond when patterns of fraud, waste, and abuse are identified. Recently, the agencies created the Orthodontic and Dental Fraud Task Force that includes personnel from HHSC, OAG, and OIG. These agencies should continue their current coordination efforts and expand these efforts beyond orthodontia if appropriate and necessary.

OIG Authority and Staffing

OIG protects the integrity of Texas Health and Human Services (HHS) programs by preventing, detecting, and pursuing instances of fraud, waste, and abuse.⁶¹ As discussed previously, the OIG has been instrumental in recent investigations into the Medicaid orthodontia, nursing facility, and medical transportation programs.

Although the OIG already has general statutory authority across the HHS programs, some providers have questioned whether the OIG is authorized to conduct investigations within the Medicaid HCBS waivers and other specific programs. In light of ongoing concerns regarding fraud, waste, and abuse within Medicaid, the Legislature should validate the OIG's responsibility for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse across all health and human services programs.

Over the last several years, OIG has vastly reduced the amount of time it takes the agency to work a case. The faster OIG can work a case, the faster the case can be referred to OAG for criminal investigation. HHSC's FY 2014-15 Legislative Appropriations Request included an exceptional item for additional FTEs at the OIG to conduct investigations, utilization review, audits, and other program integrity functions. Given the rampant fraud, waste, and abuse occurring with the Medicaid program, the Legislature should provide the OIG with additional investigations staff.

Section III. Conclusion

Recent findings of unnecessary utilization and fraud in the Medicaid orthodontics, nursing facility, and medical transportation programs have raised concerns about the processes used by the state and its contractors to determine medical necessity for Medicaid services. Although the state has taken measures to address these concerns, there are still a number of opportunities to strengthen medical necessity determination and reduce unnecessary utilization and fraud within the Texas Medicaid program.

Section IV. Recommendations

Medicaid Orthodontia and Dentistry

- **HHSC and OIG should continue current efforts to prevent overutilization and fraud within Medicaid orthodontia services**
- **HHSC and OIG should ensure that all Medicaid providers, including those contracting with MCOs, are not illegally soliciting Medicaid clients.**

- **HHSC and OIG should continue to monitor the prior authorization process of Dental Maintenance Organizations (DMOs) to ensure that prior authorizations are being done in accordance with state medical necessity criteria.**
- **Dental Service Organizations (DSOs) should be required, at a minimum, to register with the TSBDE. The Legislature should also consider funding for TSBDE before adding additional responsibilities.**
- **Dentists should be required to give parents the option of accompanying their child into the treatment room.**

Medical Transportation Program and Non-Emergency Ambulance Transportation

- **HHSC and OIG should continue efforts to prevent overutilization and fraud within MTP.**
- **HHSC should develop methods for verifying whether a client truly has no other means of transportation.**
- **The Legislature should validate that the intent of current state policies is to ensure that a provider is not serving as "another adult" authorized by a child's parent for MTP services and EPSDT visits and screenings.**
- **HHSC should review the laws and policies related to the use of non-emergent ambulance services in Medicaid to determine if any changes are needed to ensure that ambulances are only used when medically necessary and that the state is not paying for ambulance services that have been denied for payment by Medicare.**
- **DSHS and TMB should review their respective agency policies relating to the provision of non-emergency ambulance services to reduce the incidence of fraud, waste, and abuse.**

Medicaid Long-Term Care Services and Supports

- **HHSC, DADS, and OIG should continue their efforts to prevent overutilization and fraud within Medicaid LTSS.**
- **DADS should develop a process by which TMHP's automated medical necessity determinations for nursing facilities are also retrospectively reviewed for accuracy.**
- **Nursing facility services should be carved into STAR+PLUS.**
- **The OIG should continue and expand its medical necessity reviews in nursing facilities.**

Overarching Recommendations

- **HHSC and DADS should review the entire Medicaid program to determine if there are areas of medical necessity determination that need quality assurance processes in place to ensure that medical necessity is being determined correctly.**
- **HHSC and OIG should thoroughly examine the reasons behind utilization patterns, and avoid the tendency to attribute increases in service utilization to the Frew settlement.**
- **HHSC should establish data analytical processes to improve contract management, detect data trends, and identify anomalies in service utilization, payment methodologies, and adherence to requirements in Medicaid and CHIP managed care and fee-for-service contracts.**

- **HHSC and DADS should address remaining conflict of interest within the medical necessity determination process.**
- **HHSC, OAG, and OIG should continue their current coordination efforts and expand these efforts beyond orthodontia if appropriate and necessary.**
- **The Legislature should validate the OIG's responsibility for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse across all health and human services programs.**
- **The Legislature should provide the OIG with additional investigations staff.**

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- ¹ Health and Human Services Commission, *Texas Medicaid and CHIP in Perspective, Eighth Edition*, January 2011, Chapter 2 p6.
- ² *Id.* at p8.
- ³ Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services*, March 20, 2012, p12.
- ⁴ Health and Human Services Commission, *Texas Medicaid Benefit Limitations*, February 2012.
- ⁵ Information received from the Health and Human Services Commission via email on December 6, 2012.
- ⁶ *Supra* note 4.
- ⁷ Health and Human Services Commission, *Medicaid Prior Authorization Services with Descriptions*, April 2012.
- ⁸ *Supra* note 3 at p13.
- ⁹ Health and Human Services Commission, *Top 10 Prior Authorized Services in Medicaid*, April 2012. Data is based on authorizations issued and fee-for-service claims paid for dates of service 3/1/2011-9/1/2011.
- ¹⁰ Health and Human Services Commission, *Texas Medicaid Prior Authorization Overview*, April 2012.
- ¹¹ *Supra* note 3 at p14.
- ¹² Health and Human Services Commission, *Medicaid Managed Care Initiatives*, <http://www.hhsc.state.tx.us/medicaid/MMC.shtml> (Last visited December 5, 2012).
- ¹³ *Supra* note 3 at p19.
- ¹⁴ U.S. House of Representatives Committee on Oversight and Government Reform, *Uncovering Waste, Fraud, and Abuse in the Medicaid Program*, April 25, 2012.
- ¹⁵ *Supra* note 3 at p18.
- ¹⁶ *Id.* at p20.
- ¹⁷ *Supra* note 13.
- ¹⁸ *Supra* note 3 at p23.
- ¹⁹ Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services*, March 20, 2012.
- ²⁰ *Id.*
- ²¹ *Supra* note 3 at p24.
- ²² State Board of Dental Examiners, *Testimony before the Senate Committee on Health and Human Services*, March 20, 2012.
- ²³ House Bill 1, Article II, Health and Human Services Commission, Rider 82, 82nd Regular Session, 2011. (Pitts/Ogden)
- ²⁴ *Supra* note 3 at p21.
- ²⁵ *Id.* at p22.
- ²⁶ Health and Human Services Commission, *Testimony before the House Public Health Committee*, October 15, 2012, p7.
- ²⁷ Information received by the Health and Human Services Commission via email December 6, 2012.
- ²⁸ *Supra* note 26 at p7.
- ²⁹ *Supra* note 3 at p22.
- ³⁰ *Id.* at p26.
- ³¹ *Supra* note 26 at p6.
- ³² *Id.* at p10.
- ³³ *Supra* note 3 at p4.
- ³⁴ *Id.* at p7.
- ³⁵ *Supra* note 19.
- ³⁶ *Supra* note 3 at p6.
- ³⁷ *Id.* at p8.
- ³⁸ Information received from the Health and Human Services Commission via email December 6, 2012.
- ³⁹ Information received from the Health and Human Services Commission via email June 1, 2012.
- ⁴⁰ *Supra* note 3 at p10.
- ⁴¹ *Id.* at p6.
- ⁴² Information received from the Health and Human Services Commission via email December 6, 2012.
- ⁴³ House Bill 1, Article II, Health and Human Services Commission, Rider 61, 82nd Regular Session, 2011. (Pitts/Ogden)

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- ⁴⁴ Health and Human Services Commission, *Medical Transportation Program Stakeholder Forums*, <http://www.hhsc.state.tx.us/medicaid/index.html> (Last visited December 5, 2012).
- ⁴⁵ Office of the Attorney General, *Testimony before the Senate Committee on Health and Human Services*, March 20, 2012, p3.
- ⁴⁶ Department of Aging and Disability Services, *Testimony before the Senate Committee on Health and Human Services*, July 31, 2012, p2.
- ⁴⁷ Department of Aging and Disability Services, *Testimony before the Senate Committee on Health and Human Services*, March 20, 2012, p2.
- ⁴⁸ *Id.* at p3.
- ⁴⁹ *Id.* at p6.
- ⁵⁰ *Id.* at p4.
- ⁵¹ *Id.* at p5.
- ⁵² *Id.* at p7.
- ⁵³ *Id.* at p8.
- ⁵⁴ Department of Aging and Disability Services, *Testimony before the Senate Committee on Health and Human Services*, March 20, 2012.
- ⁵⁵ AARP, The Commonwealth Fund, The Scan Foundation, *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*, <http://www.longtermcorecard.org/DataByState/State.aspx?state=TX> (Last visited December 5, 2012).
- ⁵⁶ *Supra* note 47 at p9.
- ⁵⁷ *Id.* at p12.
- ⁵⁸ *Id.* at p10.
- ⁵⁹ *Id.* at p11.
- ⁶⁰ Information received from Office of Inspector General via email on December 6, 2012.
- ⁶¹ Office of Inspector General, *What is Fraud, Waste, and Abuse?*, <http://oig.hhsc.state.tx.us/oigportal/tabid/86/ShowArticle/mid/90/Default.aspx> (Last visited December 5, 2012).

Charge #5- Waiver Efficiencies: *Review the Medicaid Home and Community Based Services Waivers to identify strategies to lower costs, improve quality, and increase access to services. Areas of the review should include, but are not limited to:*

- *Functional eligibility determinations to ensure services are only being delivered to individuals that qualify;*
- *Financial eligibility determinations to ensure parental income and resources are considered when the client is a minor;*
- *Coordination of acute and long-term care services;*
- *Development and use of lower-cost community care waiver options;*
- *Coordination with the Department of Family and Protective Services (DFPS) for waiver services for children in conservatorships;*
- *Reinvesting savings into accessibility of community care for individuals waiting for services.*

Section I. Background

The Texas Medicaid program provides long-term services and supports (LTSS) to a wide range of Texans, including seniors and individuals of any age with physical or intellectual and/or developmental disabilities. In fiscal year 2012, the Texas Medicaid LTSS system served roughly 219,000 individuals a month at a total annual cost of \$5.9 billion (\$2.4 billion general revenue).¹

Several demographic trends have placed Medicaid LTSS in the forefront of state Medicaid discussions and will significantly increase demand for LTSS programs in the near future:

- From 2000 to 2030, the number of adults 60 and older with IDD in the United States is projected to nearly double, from 641,860 to 1.2 million.²
- Life expectancy for individuals with IDD has increased from 18.5 years to 66.2 years over the last several decades, a 258 percent increase.³
- Between 10,000 and 15,000 Texans 60 and older with IDD who meet DADS priority population criteria live with family caregivers who are themselves 60 or older.⁴
- In 2010, there were 3.7 million Texans over the age of 60, or about 14 percent of the total population. By the year 2040, Texas' over-60 population is expected to grow to 10 million and will comprise over 20 percent of the total population.⁵
- Within the over-60 age group, individuals 85 and older are the fastest growing group. This population is expected to triple in size by 2040.⁶

Additionally, there is an increasing preference by individuals who need LTSS to receive those services in their home or community rather than in an institutional setting. Demand for home and community-based LTSS is already outpacing the availability of services. Without changes in the way LTSS is delivered, this gap will only worsen. In order to meet the state's growing need for home and community-based LTSS, Texas should consider redesigning the current system to more efficiently serve individuals already receiving services, potentially freeing up resources to serve individuals waiting for services.

On July 31, 2012, the Senate Committee on Health and Human Services held a public hearing on Charge 5. This report provides background information on the current Medicaid LTSS system and outlines strategies to lower costs, improve quality, and increase access to services that were

discussed during the Committee's hearing. An archived video of the hearing is available online: <http://www.senate.state.tx.us/avarchive/?yr=2012>.

Medicaid LTSS Programs

The Department of Aging and Disability Services (DADS) and the Health and Human Services Commission (HHSC) are both involved in the administration and management of Medicaid LTSS programs. The LTSS system includes entitlement programs and home and community-based services (HCBS) waivers.

Entitlement Programs

Under an entitlement program, the state is federally required to provide services to anyone who meets the eligibility requirements and applies for the program. There cannot be a waiting list for entitlement programs. Medicaid LTSS entitlement programs include the *Nursing Facility Program* for individuals with medical or physical disabilities and the *Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) Program* for individuals with intellectual and developmental disabilities (IDD). ICF/IIDs include large state supported living centers (SSLCs) and smaller residential facilities located in the community.

The Medicaid LTSS system also comprises several community-based entitlement services: Primary Home Care (PHC), Community Attendant Services (CAS), and Day Activity and Health Services (DAHS). PHC and CAS provide services such as escorting individuals to medical appointments, assistance with housekeeping activities, and personal care.⁷ The DAHS program, also referred to as “adult day care” or “adult day services,” provides daytime services such as nursing and personal care; physical rehabilitation; social, educational, and recreational activities; and transportation.⁸ These programs only serve individuals with medical or physical disabilities. Adults with IDD do not have similar access to community-based entitlement services unless they also have a medical/physical disability that qualifies them for PHC, CAS, or DAHS. Children with IDD can access basic attendant care and habilitation through the Personal Care Services (PCS) program.

Hospice, which can be provided in a home, community, or facility setting, provides palliative care including medical, social, and support services. Hospice is an entitlement service for individuals who have a terminal illness and have a physician’s prognosis of six months or less.⁹

Appendix 1 provides an overview of the Texas Medicaid LTSS entitlement programs.¹⁰

Home and Community-Based Services Waiver Programs

Federal laws and regulations provide states flexibility to design waiver programs to address the needs of specific populations. A waiver is an exception to the usual Medicaid requirements granted to a state by the federal Centers for Medicare and Medicaid Services (CMS). In regards to Medicaid LTSS, home and community-based services (HCBS) waivers allow states to provide services to individuals in their homes and the community rather than in an institutional setting (nursing facility or ICF/IID). A state must ensure that a waiver is cost neutral when compared to the cost of the institutional entitlement.¹¹

As indicated by Table 1, Texas has three HCBS waiver programs that serve individuals who may otherwise receive services in a nursing facility, and four HCBS waiver programs that serve individuals who may otherwise receive services in an ICF/IID.¹²

Table 1. Texas Medicaid HCBS Waivers

Nursing Facility Waiver Programs	ICF/IID Waiver Programs
Community Based Alternatives (CBA)	Home and Community-based Services (HCS)
Medically Dependent Children Program (MDCP)	Community Living Assistance and Support Services (CLASS)
STAR+PLUS	Texas Home Living (TxHmL)
	Deaf Blind with Multiple Disabilities (DBMD)

Appendix 2 provides more detailed overviews of the HCBS waiver programs.¹³ As outlined by these tables, the populations served and types of services available vary between the various HCBS waiver programs.

LTSS Eligibility

To qualify for Medicaid LTSS, individuals must meet both financial and functional eligibility criteria. HHSC is responsible for financial eligibility and DADS is responsible for functional eligibility.¹⁴

Financial eligibility for Medicaid LTSS is automatically established if an individual is eligible for Supplemental Security Income (SSI). SSI is a federal program that provides supplemental income to individuals who are elderly or have disabilities and have little or no income. However, individuals not eligible for SSI can still qualify for Medicaid LTSS if they are at or below 300 percent of the SSI income level (\$2,094/month).¹⁵ The one exception is TxHmL, which has an income limit of 100 percent of the SSI income level.¹⁶

Functional eligibility is based on individuals' need for services resulting from physical, intellectual, or developmental disabilities and varies across different programs and services.¹⁷

Demand for HCBS Waivers

As mentioned previously, demand for HCBS waiver programs continues to outpace the availability of slots. This continued growth in demand is attributable to state population growth, increases in autism and related conditions, and increased awareness of waiver services.

Unlike entitlement programs, the availability of waiver slots is not guaranteed and is determined by legislative appropriations. As a result, not all individuals that qualify for a waiver program receive waiver services. Individuals interested in receiving services through an HCBS waiver may add their name to an "interest list" until services become available. Interest lists are operated on a first-come, first-served basis. The eligibility determination process (functional and financial) begins once an individual's name comes to the top of the interest list. The number of individuals on interest lists for each of the HCBS waiver programs as of September 30, 2012 is listed in Table 2.¹⁸

As depicted in Table 2, there are a number of individuals that do not enroll in a waiver program once their name reaches the top of the interest list ("Denied/Declined"). These individuals may not enroll in a waiver program for a number of reasons, such as: individual declines the waiver slot because of other services being received, individual fails to satisfy eligibility requirements, DADS is unable to locate the individual, or the individual fails to respond to DADS.

Table 2. HCBS Waiver Interest Lists

September 2012 Interest List Releases Summary Fiscal Years 2012 - 2013							
	CBA	STAR+PLUS	CLASS	DBMD	MDCP	HCS	TOTAL
Number of Clients on IL - Aug. 31, 2011	30,148	10,741	38,258	420	22,063	52,676	154,306
Total Released/ Removed from IL*	19,677	15,028	252	37	1,223	94	36,301
Enrolled	2,363	745	102	5	225	23	3,463
In the Pipeline	1,696	3,281	111	8	358	65	5,519
Denied/Declined	15,608	11,002	39	24	640	6	27,319
Current IL – Sept. 30, 2012	11,172	11,056	44,039	537	25,810	60,832	**153,446
* The counts for CBA, CLASS, DBMD, and MDCP include releases from FY10-11 that were still in the pipeline as of August 31, 2011.							
** Count is duplicated. The unduplicated count is 107,498.							

Also, as indicated in the table above, only the CBA waiver program experienced a net reduction in its interest list size from FY 2012 to FY 2013. This is due in large part to the interaction between the CBA waiver and STAR+PLUS (discussed in the Analysis section).

More information about the Texas Medicaid LTSS programs, including HCBS waiver programs, is available online: <http://www.dads.state.tx.us/ltss/>.

Section II. Analysis

This section outlines opportunities and makes recommendations for improving the quality and efficiency of the HCBS waiver programs with the ultimate goals of improving access to services, ensuring that the LTSS system is prepared for the rapid growth in demand expected in the near future, and efficiently using state resources.

Functional Eligibility Determination

As mentioned previously, an individual must meet functional eligibility criteria in order to qualify for Medicaid LTSS. Functional eligibility criteria vary for each program. The functional eligibility requirements for the various HCBS waivers and LTSS entitlement programs are listed in Table 3.¹⁹

Table 3. Medicaid Functional Eligibility by Program

Program	Functional Eligibility
Nursing Facility Community Based Alternatives (CBA) STAR+PLUS Medically Dependent Children Program (MDCP) Program of All-Inclusive Care for the Elderly (PACE)	"Medical necessity" - the functional determination that an individual requires the services (supervision, assessment, planning, and intervention) of a licensed nurse on a regular basis.
Home and Community-based Services (HCS) Texas Home Living (TxHmL)	Psychologist's determination of an Intelligence Quotient of 75 or below.
Community Living Assistance and Support Services (CLASS)	Physician's diagnosis of a related condition.
Deaf-Blind with Multiple Disabilities (DBMD)	DADS determines functional eligibility based on provider's assessment and other screening instruments. Also requires physician statement certifying diagnosis.
Primary Home Care (PHC) Community Attendant Services (CAS)	Physician statement certifying a medical diagnosis and the need for skilled services.
Day Activity and Health Services (DAHS)	A physician's order certifying a medical need resulting in a functional limitation based on activities of daily living.

Functional Assessment Tool

There are concerns that the current functional assessment process for HCBS waivers for individuals with IDD (HCS, CLASS, TxHmL, and DBMD) places individuals into a specific program based on their diagnosis or onset of disability rather than on the individual’s service needs. This approach can lead to the placement of individuals in a program that does not offer all of the services they need, and alternatively, can lead to individuals being placed in a program that offers more services than they need. An individual may wait for years on an interest list receiving little or no services, but once he/she is in the waiver program, may receive costly services that are unnecessary.

Another concern among advocates is that the current assessment process does not adequately address behavioral health needs. For example, an individual with IDD may be physically capable of completing a task (e.g., taking out the trash); however, without proper supports such as instruction, the individual may be unable to accomplish the task.

There is general consensus among advocates and state officials that a new assessment process is needed. One approach that has been suggested is a person-centered, self-directed process utilizing a more precise assessment tool and resource allocation process. Currently Texas does not have a single standardized assessment instrument for all HCBS waivers. Instead, Texas uses separate functional assessment instruments for eligibility, identification of support needs, and service planning. Additionally, there are other instruments the state uses to collect more specific information.²⁰

DADS is currently exploring a variety of assessment tools and resource allocation processes used by other states. A more precise assessment tool will be critical in ensuring that individuals receive the services and supports they need – no more, no less.

Addressing Conflict of Interest

In many of the HCBS waiver programs, the entity authorizing services is also the entity providing the services, creating an inherent conflict of interest.

To address conflict of interest, DADS conducts utilization reviews across all entitlement and waiver programs to ensure that individuals receive the appropriate amount and level of services and supports.²¹ In FY 2011, DADS achieved \$13 million (All Funds) in cost savings as a result of utilization review.²² However, there are limitations to utilization review. Utilization review typically tests only a sample, is usually done after services are already being delivered, and does not actually eliminate conflict of interest.

Senate Bill 7 by Senator Nelson (82nd Legislature, 1st Called Session) implemented an objective assessment process for acute nursing services, which includes skilled nursing services, home health aide services, and private duty nursing. An objective assessment process ensures that clients receive an appropriate amount of services by removing any conflict of interest that may result from having the same entity conduct the assessment and deliver services. It may be possible for DADS to use the results from its utilization reviews to determine whether there are certain HCBS programs or services that have particularly high rates of discrepancy between services authorized and services needed, and would benefit from an objective assessment process similar to what has been implemented for acute nursing services.

DADS has also applied for the Balancing Incentives Program (BIP), a federal initiative aimed at incentivizing states to rebalance their LTSS system by investing more in community care than institutional care. BIP has several requirements, one of which is conflict-free case management for Medicaid home and community-based LTSS by September 2015.²³ Conflict-free case management means separation between entities that conduct eligibility determinations and case management and entities that provide the services. The federal Centers for Medicare and Medicaid Services (CMS) has yet to determine whether “conflict-free case management” will mean using an independent third party, or allowing the same entity to provide services and case management as long as there is a “firewall” between the two operations. Because managed care organizations (MCOs) do not directly employ their providers, there is an inherent “firewall” or conflict-free case management in the managed care setting.

In order to further ensure that individuals are receiving the appropriate amount of services, DADS should continue its existing efforts to eliminate conflict of interest in the Medicaid HCBS waiver programs.

Financial Eligibility Determination

TxHmL is the only Medicaid HCBS waiver that considers parental income to determine financial eligibility.²⁴ All of the other HCBS waivers only consider the child’s income, which means that for nearly all of the HCBS waivers, children are eligible for services regardless of their parents’ income. There are concerns that children in high-income families, and other families that have

the financial ability to contribute to the child's cost of care, are accessing Medicaid HCBS waiver services with no financial contribution.

States are federally allowed to require parents to contribute to the cost of their children's care.²⁵ To ensure that HCBS services are available to all who need them, the state should implement parental cost sharing for children receiving Medicaid LTSS. Rather than using parental income to determine eligibility for the program, parental income would only be used to determine the amount of the parental contribution *after* a child is determined eligible for the program. Many advocates have indicated that a parental contribution requirement is reasonable, but recommended that the contribution be applied across all settings and that families be involved in the development of the fee structure.

Coordination of Acute Care and LTSS

Improving the coordination of acute care services and LTSS offers great potential for improving the quality and efficiency of the Medicaid program. However, many individuals receiving both acute care Medicaid and LTSS still receive these services separately with no coordination.

Acute Care Services

Before acute care and LTSS can be coordinated, the state should ensure that all individuals in Medicaid, including individuals with disabilities, are receiving their acute care services through the most appropriate capitated managed care model. Currently, enrollment in managed care for certain populations is voluntary. The Legislature should eliminate any remaining voluntary managed care enrollment so that all Medicaid clients receive coordinated acute care services.

Statewide STAR+PLUS Expansion

Once acute care services are coordinated, the state should ensure that all individuals receiving both acute care services and LTSS receive their services through an integrated capitated managed care program.

The STAR+PLUS program is unique among the waiver programs in that it is actually a capitated managed care program that integrates acute care and LTSS. STAR+PLUS services are available to individuals 21 years and older who would otherwise receive care in a nursing facility (medical and physical disabilities). Under STAR+PLUS, managed care organizations (MCOs) are responsible for coordinating both acute care services and LTSS through service coordinators.²⁶

Although STAR+PLUS is a waiver program, it also acts as an entitlement program for certain populations and is responsible for significantly reducing interest lists for HCBS waivers, such as CBA, that serve individuals who would otherwise be in a nursing facility. Recent expansions of STAR+PLUS by the 82nd Legislature have greatly increased access to integrated acute and long-term care services for individuals with physical disabilities. However, rural areas of the state still remain outside of the STAR+PLUS service area. The state should expand STAR+PLUS to the remainder of the state. A map of current STAR+PLUS service areas, including expansions by the 82nd Legislature is available online: <http://www.hhsc.state.tx.us/medicaid/MMC/STARPLUS-Service-Area-Map.pdf>.

Currently, individuals with IDD are not served through an integrated managed care model such as STAR+PLUS. Individuals with IDD will not have a truly redesigned delivery system without addressing the issue of coordination between acute care services and LTSS. Whether through STAR+PLUS or another more appropriate capitated managed care model that integrates acute care services and LTSS, individuals with IDD should receive services through a managed care model to ensure that all of their services are being coordinated.

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

Another capitated program, the Program of All-Inclusive Care for the Elderly (PACE), also integrates acute care and LTSS. PACE serves individuals age 55 and older who would otherwise receive services in a nursing facility. PACE receives a monthly capitated fee and provides participants with all health-related services (e.g., dentistry, podiatry, social services, in-home care, meals, transportation, day activities, and housing assistance).²⁷ Current PACE service areas include El Paso, Amarillo, and Lubbock. DADS has included an exceptional item in the agency's FY 2014-15 LAR requesting \$4.8 million to expand the availability of the PACE program. This exceptional item would add slots to existing PACE sites (24 new slots for Amarillo, 24 new slots for Lubbock, and 48 new slots for El Paso) and add two new PACE sites with 150 slots each.²⁸

Behavioral Supports for Individuals with IDD

Behavioral health services have traditionally been considered public health services separate from Medicaid LTSS. However, a large percentage of individuals with IDD who receive LTSS have co-occurring behavioral health needs. Proper behavioral supports can help individuals with IDD avoid institutionalization resulting from an acute behavioral crisis.

Almost 66 percent of the individuals residing in the SSLCs have a dual diagnosis (mental illness or substance abuse co-occurring with IDD). Nearly 90 percent of individuals admitted to SSLCs in the past two years have a dual diagnosis. On average, nearly 25 percent of individuals in DADS HCBS waiver programs have a dual diagnosis. The rate of dual diagnosis is higher in the Home and Community-based Services (HCS) waiver at 36 percent of enrollees with a dual diagnosis.²⁹ Individuals with IDD are also more likely than the general population to be abused and neglected which can often lead to trauma resulting in future behavioral challenges.³⁰

Trauma-Informed Care

There are concerns that the existing culture of care for individuals with IDD attributes challenging behaviors to an individual's disability rather than to the individual's mental health. DADS has partnered with the Hogg Foundation to provide training and technical assistance to providers who serve individuals with IDD on a new culture of care called "trauma-informed care." Trauma-informed care focuses on understanding the impact of trauma on behavior and using that understanding to avoid triggers that may exacerbate challenging behaviors and cause re-traumatization. The Hogg Foundation's efforts have focused on using trauma-informed care to reduce the use of restraint in institutional and community-based settings. In February 2012, the Hogg Foundation coordinated trainings at the Mexia and San Angelo SSLCs. Community providers were also invited to attend. The Hogg Foundation will continue to offer technical assistance to providers as they plan and implement strategies learned at the training sessions.³¹

Behavioral Intervention Teams

There are also concerns that services provided under the HCBS waiver programs do not provide adequate capacity to serve individuals with high behavior support needs. These individuals are at risk of institutionalization if their behavioral needs cannot be met in a HCBS waiver program. There is also a concern that the lack of capacity to serve these individuals in the HCBS waivers could delay or prevent their movement from an institution to a community setting.

To address co-occurring behavioral needs in the HCBS waiver programs and avoid institutionalization of individuals with behavioral needs, DADS should develop and implement specialized training for providers, family members, caregivers, and first responders providing direct services and supports to individuals with IDD and behavioral health needs. DADS could pilot the use of “behavioral intervention teams” to provide services and supports to the individual and the individual’s family so that the individual may avoid institutionalization resulting from an acute behavioral crisis. The teams could be comprised of a combination of psychiatrists, psychologists, physicians, nurses, behavior analysts, social workers, and crisis coordinators.³²

Dual Eligible Integrated Care Project

For individuals eligible for both Medicare and Medicaid, Medicare predominately pays for acute care services while Medicaid covers LTSS. This split responsibility results in fragmentation of care because services are not coordinated between the two programs. This division of services also means that any savings in acute care due to improvements in the delivery of Medicaid LTSS for dual eligibles results in savings to the federal government, not the state.

To address this issue, the federal Centers for Medicare and Medicaid Services (CMS) presented states with an opportunity to develop demonstration projects to integrate Medicare and Medicaid services for dual eligible individuals. Participating states will get to keep a portion of the Medicare savings.³³ HHSC submitted an application for the Dual Eligible Integrated Care Project to CMS on May 31, 2012. At the time this report was published, CMS had not issued a decision on the Texas application.³⁴

Development of Lower Cost Community Options

The most significant barrier to serving more individuals in the HCBS waivers is the high cost of these programs. Table 4 lists the average budgeted monthly cost of serving an individual in each of the HCBS waiver programs for FY 2013.³⁵

Table 4 Average Monthly Cost Per Individual

	Budgeted avg. monthly cost per individual served (FY 2013)
Home and Community-Based Waivers	
Community Based Alternatives (CBA)	\$1,378.36
Home and Community-Based Services (HCS)	\$3,449.22
Community Living Assistance and Support Services (CLASS)	\$3,503.09
Deaf-Blind Multiple Disabilities (DBMD)	\$4,191.29
Medically Dependent Children Program (MDCP)	\$1,437.76
Texas Home Living Waiver	\$800.00

In order to address the HCBS interest lists and increase access for individuals waiting for services, the state must find a more efficient way to serve individuals in the community. By identifying lower cost options for providing basic services and supports in the community, the state can help more individuals stay in the community than it can now under the more costly HCBS waivers.

Pilots to Test Innovative Delivery Models

Before transitioning individuals with IDD to a managed care model for LTSS, DADS should test the capitated model through pilot programs. The pilots should be designed to increase access to LTSS, improve quality and service coordination, promote person-centered planning and self-direction, and promote efficiency and the best use of funding. The pilots would help the state determine whether managed care strategies can achieve sufficient savings to serve more individuals in the community.

Basic Attendant Services for Individuals with IDD

As mentioned in the Background, adults with IDD do not have access to basic attendant services unless they are in a HCBS waiver or also have a physical disability that qualifies them for an entitlement program. Basic attendant services are low-cost services that can divert individuals with disabilities from more expensive institutional settings. For more than 30 years, individuals with physical disabilities have been able to access community-based attendant services as a Medicaid entitlement. HHSC should implement the most cost-effective option for the delivery of basic attendant and habilitation services for individuals with IDD through STAR+PLUS.

Increasing Low-Cost Housing Options for Individuals with IDD

Current federal and state regulations limit choice of residential setting for individuals with IDD. Group care in Texas is limited to three-bed or four-bed settings, with limitations on how close these homes can be. Even though HCS recipients are responsible for room and board, current regulations do not allow them to live in congregate settings (i.e. settings in which individuals with IDD are living close to others with IDD, receiving shared services in a setting designated for individuals with disabilities).³⁶

In order to provide individuals with IDD greater choice and flexibility in residential options, HHSC/DADS should revise state rules, within the parameters of federal law, to allow a wider

range of residential options, including settings in which residences (homes, apartments, condominiums, etc.) may be close to each other. This would allow the housing market to include more affordable options for individuals with IDD receiving LTSS.³⁷ The use of other residential settings when appropriate is both more cost-effective and offers individuals greater autonomy and independence.

HHSC/DADS should also increase coordination with the Department of Housing and Urban Development (HUD), Texas Department of Housing and Community Affairs, and public housing authorities to expand opportunities for housing supports to meet the increasingly complex needs of individuals with IDD as they age.

State Supported Living Centers

Between September 2006 and June 2012, the census in State Supported Living Centers (SSLCs) decreased from 4,924 to 3,831. This is a decrease of 1,093 individuals, or 22.2 percent. DADS anticipates that this reduction will continue at approximately 6 percent per year. As the SSLC census declines, maintenance costs for the SSLCs continue to increase due to aging facilities. In January 2011 the Legislative Budget Board (LBB) released a report recommending the closure of one or more SSLCs.³⁸ Advocates for increased community-based services for individuals with IDD recommend consolidating the SSLCs and reinvesting the savings to serve more individuals with IDD in the community through HCBS waivers.

Improve Coordination for Children in DFPS Conservatorship

The 82nd Legislature appropriated funding to provide 196 targeted HCS waiver slots per biennium for children with IDD who are aging out of Department of Family Protective Services (DFPS) foster care. As of the Committee's July hearing, there were 64 younger children (not aging out) with IDD who were residing in DFPS General Residential Operations (GRO) facilities. In April 2012, then DADS Commissioner Chris Traylor carved out 10 HCS slots from the HCS slots appropriated to DADS to be used for these younger children. In order for these children to become a target population for the Promoting Independence Initiative, the 83rd Legislature would need to authorize ongoing HCS waiver slots for this population. DADS is working to amend the agency's FY 2014-15 LAR to include an exceptional item requesting 25 new HCS waiver slots for these children.³⁹

Other Issues Discussed

There were several other issues discussed during the Committee's July hearing that did not fit into the areas discussed above, but are relevant to the HCBS waiver programs.

Consumer-Directed Services

The consumer-directed services (CDS) option allows individuals receiving services through DADS home and community-based programs to hire and manage the people who provide services to them. Supporters of CDS believe this option encourages personal responsibility, ownership, and self-determination. The public members of HHSC's Consumer Direction Workgroup recently released their biennial report with recommendations for expanding the use of the CDS model. The workgroup's report is available online:

<http://www.hhsc.state.tx.us/reports/2012/Consumer-Direction-Workgroup-Biennial-Report.pdf>.

Another concept similar to CDS is the "microboard." A microboard is a small group of family and friends who form a non-profit organization dedicated to providing support to an individual with IDD on a voluntary basis. A microboard provides social opportunities, helps individuals with IDD participate in their community, and manages all aspects of the individual's care (e.g., medical care, transportation, job searches).⁴⁰ Microboards are currently allowed to apply as providers under the HCS and TxHmL waiver programs. More information about microboards is available online: http://www.thearcoftexas.org/site/PageServer?pagename=partners_microboard.

Personal Attendants

Personal attendants help individuals with disabilities with important daily activities such as bathing, eating, preparing meals, and keeping their homes clean. These services help individuals with disabilities live in their homes rather than in an institutional setting. However, several issues impact the personal attendant workforce.

Wages

Currently, personal attendants are paid different wages depending on where the services are being delivered. Personal attendants working in institutional settings are paid more than those working in the community. Advocates for personal attendants and individuals living in the community would like to see these wages equalized so that wages in the community are competitive with those in the institutions.

Recruitment

With demand for community-based LTSS increasing, active recruitment efforts will be critical to ensure that there are enough personal attendants to provide services. HHSC/DADS should explore new strategies for recruiting personal attendants. Potential opportunities include training individuals with disabilities to be personal attendants for others and outreaching to recipients of the Temporary Assistance for Needy Families (TANF) program.

Section III. Conclusion

Without a redesign of the way Medicaid long-term services and supports are delivered, Texas will not be able to ensure that services are available to meet the increasing demand expected in the near future. The 83rd Legislature must act to develop a LTSS system that more efficiently serves individuals, allowing any savings to be reinvested into increasing access to care for individuals waiting for services.

Section IV. Recommendations

Functional Eligibility

- **DADS should continue efforts to eliminate conflict of interest in the Medicaid HCBS waiver programs.**

Financial Eligibility

- **The state should establish parental cost-sharing for children receiving Medicaid LTSS based on parental income.**

Coordination of Acute Care and LTSS

- **The state should eliminate any remaining voluntary managed care enrollment so that all Medicaid clients receive coordinated acute care services.**
- **The state should expand STAR+PLUS statewide to include the Medicaid Rural Service Area (MRSA).**
- **Individuals with IDD should receive services through an integrated capitated managed care model to ensure that all of their services are being coordinated.**
- **DADS should develop and implement specialized training for providers, family members, caregivers, and first responders providing direct services and supports to individuals with IDD and behavioral health needs.**

Developing Lower Cost Community Options

- **DADS should establish pilot programs to test capitated managed care strategies for serving individuals with IDD.**
- **HHSC should implement the most cost-effective option for the delivery of basic attendant and habilitation services for individuals with IDD through STAR+PLUS.**
- **HHSC/DADS should revise state rules, within the parameters of federal law, to allow a wider range of residential options for individuals with IDD.**
- **HHSC/DADS should increase coordination with the Department of Housing and Urban Development (HUD), Texas Department of Housing and Community Affairs, and public housing authorities to expand opportunities for housing supports to meet the increasingly complex needs of individuals with IDD as they age.**

Addressing LTSS Workforce

- **HHSC/DADS should explore new opportunities for recruiting personal care attendants.**

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- ¹ Information received from Department of Aging and Disability Services via email on November 6, 2012.
- ² Department of Aging and Disability Services, *Testimony before the Senate Committee on Health and Human Services*, July 31, 2012, p15.
- ³ *Id.*
- ⁴ Department of Aging and Disability Services, *Individuals Who Are Aging with Intellectual and Developmental Disabilities and DADS Services*, June 2012, p1.
- ⁵ Department of Aging and Disability Services, *Trends/Critical Issues/Future Implications/Challenges*, http://www.dads.state.tx.us/news_info/publications/planning/stateplanonaging/2011-2013/trends.html (Last visited December 3, 2012).
- ⁶ *Id.*
- ⁷ Department of Aging and Disability Services, *Primary Home Care*, <http://www.dads.state.tx.us/services/faqs-fact/phc.html> (Last visited December 3, 2012).
- ⁸ Department of Aging and Disability Services, *Day Activity and Health Services*, <http://www.dads.state.tx.us/services/faqs-fact/dahs.html> (Last visited December 4, 2012).
- ⁹ Department of Aging and Disability Services, *Hospice Program*, <http://www.dads.state.tx.us/services/faqs-fact/hospice.html> (Last visited December 4, 2012).
- ¹⁰ Information received from Department of Aging and Disability Services via email November 28, 2012.
- ¹¹ *Supra* note 2 at p3.
- ¹² *Id.* at p5.
- ¹³ *Supra* note 8.
- ¹⁴ *Supra* note 2 at p1.
- ¹⁵ *Id.* at p2.
- ¹⁶ *Id.* at p9.
- ¹⁷ *Id.* at p2.
- ¹⁸ Department of Aging and Disability Services, *Interest List Reduction*, <http://www.dads.state.tx.us/services/interestlist/index.html> (Last visited December 3, 2012).
- ¹⁹ Department of Aging and Disability Services, *Balancing Incentive Program Application*, November 29, 2102, <http://www.dads.state.tx.us/providers/pi/bip/BIPApplication-6-29-12.pdf>, p34.
- ²⁰ *Id.* at p35.
- ²¹ *Supra* note 2 at p8.
- ²² Information received from Department of Aging and Disability Services via email on February 10, 2012.
- ²³ Centers for Medicare and Medicaid Services, Letter from Director Cindy Mann to State Medicaid Directors, <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/11-010.pdf>.
- ²⁴ *Supra* note 2 at p9.
- ²⁵ *Id.*
- ²⁶ Health and Human Services Commission, *STAR+PLUS*, <http://www.hhsc.state.tx.us/starplus/overview.shtml> (Last visited December 3, 2012).
- ²⁷ Department of Aging Disability Services, *Program of All-Inclusive Care for the Elderly*, <http://www.dads.state.tx.us/providers/PACE/index.cfm> (Last visited December 3, 2012).
- ²⁸ Department of Aging and Disability Services, *Legislative Appropriations Request FY 2014-2015*.
- ²⁹ Information from Department of Aging and Disability Services August 17, 2012.
- ³⁰ Hogg Foundation for Mental Health, *Reducing Seclusion and Restraint in Texas*, http://www.hogg.utexas.edu/initiatives/seclusion_restraint.html (Last visited December 3, 2012).
- ³¹ *Id.*
- ³² *Supra* note 27.
- ³³ Health and Human Services Commission, *Texas Dual Eligible Integrated Care Project*, <http://www.hhsc.state.tx.us/medicaid/dep/index.shtml> (Last visited November 29, 2012).
- ³⁴ *Id.*
- ³⁵ *Supra* note 26.
- ³⁶ *Supra* note 27.
- ³⁷ *Id.*
- ³⁸ Legislative Budget Board, *Transform State Residential Services for Persons with Intellectual and Developmental Disabilities*, January 2011.

³⁹ Information received from Department of Aging and Disability Services via email December 3, 2012.

⁴⁰ The Arc of Texas, *Texas Microboard Collaboration: Self-Directed Support Corporations*,
http://www.thearcoftexas.org/site/PageServer?pagename=partners_microboard (Last visited December 3, 2012).

Appendix 1

**Department of Aging and Disability Services (DADS) – Community Care Program/Long-Term Care Services and Supports
Medicaid Entitlement Programs**

Program Feature	Nursing Facility (NF)	Primary Home Care (PHC)	Community Attendant Services (CAS)	Day Activity and Health Services (DAHS) – Medicaid – Title XIX	Hospice	Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID)
Eligibility						
Citizenship or Legal Permanent Residency Required?	Yes	Yes	Yes	Yes	Yes	Yes
Age Served	Any Age	21 and above. (HHSC provides a similar service to individuals under age 21)	Any Age	Any Age *People under 18 are not ineligible; however, they are not able to attend DAHS due to licensure issues	Any Age	Any Age
Functional Eligibility	Requires certification that the individual has a medical condition that requires daily skilled nursing care and must reside in a Medicaid-contracted long-term care facility for 30 consecutive days	Requires a medical practitioner’s statement that the individual’s medical condition causes a functional limitation for at least one personal care task	Requires a medical practitioner’s statement that the individual’s medical condition causes a functional limitation for at least one personal care task	Requires medical diagnosis and physician’s orders requiring care, monitoring, or intervention by a licensed vocational nurse or a registered nurse at the facility.	Requires certification by a physician that person has less than six months to live	Individual must have mild to extreme deficits in adaptive behavior and have an IQ score of 69 or below or an IQ score of 75 or below with a primary diagnosis of a related condition; or individual must have a primary diagnosis of a related condition with moderate to extreme deficits in adaptive behavior. Individual must be able to participate and benefit from active treatment (training, etc.)
Services						
Description	Institutional care to Medicaid recipients whose medical condition requires the skills of licensed nurses on a regular basis. continues to regulate facilities	A non-technical, non-medical attendant care service for recipients age 21 or over whose chronic health problems impair their ability to perform activities of daily living.	A non-technical, non-medical attendant care service for recipients of all ages whose chronic health problems impair their ability to perform activities of daily living and whose income otherwise makes them ineligible for PHC	Provides daytime services Monday through Friday to individuals residing in the community to provide an alternative to placement in nursing facilities and other institutions	Provides palliative care consisting of medical, social, and support services for a period of six months to persons who are terminally ill	Provide residential services for individuals with an intellectual disability or related condition
Consumer-directed Services (CDS) option available	No	Yes	Yes	No	No	No

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**Department of Aging and Disability Services (DADS) – Community Care Program/Long-Term Care Services and Supports
Medicaid Entitlement Programs**

Program Feature	Nursing Facility (NF)	Primary Home Care (PHC)	Community Attendant Services (CAS)	Day Activity and Health Services (DAHS) – Medicaid – Title XIX	Hospice	Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID)
Provider Requirements						
Licensure/certification requirements Note: Under the CDS option, the CDS Agency, a fiscal /employer agent, is not required to be licensed but must meet DADS' training and contracting requirements.	Licensed (NF) and certified	Licensed (HCSSA) and certified	Licensed (HCSSA) and certified	Licensed (HCSSA) and certified	Licensed (HCSSA) and certified	Private Providers Licensed (ICF/IID) and certified; Public Providers certified (ICF/IID)

Appendix 2

Medicaid Long-term Services and Supports Waiver Programs

Program Feature	STAR+PLUS	CBA: Community-Based Alternatives	MDCP: Medically Dependent Children Program	CLASS: Community Living Assistance and Support Services	DBMD: Deaf-Blind Multiple Disabilities	HCS: Home and Community-based Services	TxHmL: Texas Home Living
Waives off	Nursing facility eligibility	Nursing facility eligibility	Nursing facility eligibility	ICF/IID eligibility	ICF/IID eligibility	ICF/IID eligibility	ICF/IID eligibility
Year initiated	1998	1994	1984	1991	1995	1985	2004
Eligibility							
Age Served	21+	21+	Children (younger than age 21)	All ages	All ages	All ages	All ages
Functional eligibility	Physician certification of need for daily or regular skilled nursing (medical necessity)	Physician certification of need for daily or regular skilled nursing (medical necessity)	Physician certification of need for daily or regular skilled nursing (medical necessity)	Related condition to intellectual or developmental disability with onset prior to age 22	Deaf-blindness/condition that resulted in deaf-blindness prior to age 22 and a third disability, such as intellectual disability or a related condition that impairs independent functioning	Diagnosis of intellectual disability or related condition of intellectual or developmental disability with an IQ of 75 or below	Diagnosis of intellectual disability or related condition of intellectual or developmental disability with an IQ of 75 or below
Financial eligibility	Monthly income within 300% of SSI monthly income limit (\$2,130)	Monthly income within 300% of SSI monthly income limit (\$2,130)	Monthly income within 300% of SSI monthly income limit (\$2,130)	Monthly income within 300% of SSI monthly income limit (\$2,094)	Monthly income within 300% of SSI monthly income limit (\$2,094)	Monthly income within 300% of SSI monthly income limit (\$2,094)	SSI; MAO; under 20 and financial responsibility of DFPS in foster home or group home with foster parent; Medicaid for Youth Transitioning Out of Foster Care; or being member of TANF family.
Consideration of parental income	NA (children not served)	NA (children not served)	Not considered	Not considered	Not considered	Not considered	Considered
Services							
Examples of services common across waivers	<ul style="list-style-type: none"> • Direct care services (personal attendant services) • Nursing • Professional therapies (speech, physical, occupational) • Dental • Adaptive aids 	<ul style="list-style-type: none"> • Direct care services (personal attendant services) • Nursing • Professional therapies (speech, physical, occupational) • Dental • Adaptive aids 	<ul style="list-style-type: none"> • Direct care services (respite by an attendant or a licensed nurse) • Adaptive aids • Minor home modifications • Transition Assistance Services 	<ul style="list-style-type: none"> • Direct care services (habilitation) • Nursing • Professional therapies (speech, physical, occupational) • Dental • Behavioral supports 	<ul style="list-style-type: none"> • Direct care services (habilitation) • Nursing • Professional therapies (speech, physical, occupational) • Dental • Behavioral supports 	<ul style="list-style-type: none"> • Direct care services (supported home living) • Nursing • Professional therapies (speech, physical, occupational) • Dental • Adaptive aids • Minor home modifications 	<ul style="list-style-type: none"> • Direct care services (community support) • Nursing • Professional therapies (speech, physical, occupational) • Dental • Adaptive aids

Appendix 2

Medicaid Long-term Services and Supports Waiver Programs

Program Feature	STAR+PLUS	CBA: Community-Based Alternatives	MDCP: Medically Dependent Children Program	CLASS: Community Living Assistance and Support Services	DBMD: Deaf-Blind Multiple Disabilities	HCS: Home and Community-based Services	TxHmL: Texas Home Living
	<ul style="list-style-type: none"> Minor home modifications Transition Assistance Services 	<ul style="list-style-type: none"> Minor home modifications Transition Assistance Services 		<ul style="list-style-type: none"> Adaptive aids Minor home modifications Transition Assistance Services 	<ul style="list-style-type: none"> Adaptive aids Minor home modifications Transition Assistance Services 		<ul style="list-style-type: none"> Minor home modifications
Examples of services unique to a waiver	<ul style="list-style-type: none"> Emergency response services Home-delivered meals Assisted living Adult foster care 	<ul style="list-style-type: none"> Emergency response services Home-delivered meals Assisted living Adult foster care 	<ul style="list-style-type: none"> Adjunct support services 	<ul style="list-style-type: none"> Support family services Continued family services Specialized therapies Hippo therapy Aquatic therapy Music therapy Recreational therapy Massage therapy Dietary services Auditory enhancement training 	<ul style="list-style-type: none"> Intervener services Assisted living 	Residential services <ul style="list-style-type: none"> 3- or 4-person group home Foster care home 	No unique services
Case management provider	Managed care organization (MCO) service coordinators (RNs or LVNs)	DADS staff separate from direct services	DADS staff separate from direct services	Contracted case management agencies separate from the direct service provider	Contracted agencies that provide case management services and direct services	Local Authorities	Local Authorities
Available consumer-directed services (CDS) options	Personal assistance services and respite.	Personal assistance services, respite, nursing, professional therapies, support consultation	Respite (provided by nurse or attendant), adjunct support services (nurse and attendant)	Habilitation, respite, nursing, professional therapies, support consultation	Habilitation, intervener, respite, support consultation	Supported home living, respite, support consultation	All services and support consultation
Individual annual maximum cost	Less than 200% of Resource Utilization Group (RUG - institutional cost) for the individual – ranges from \$63,349 for an individual with basic care needs to \$260,011 for an individual with heavy	Less than 200% of Resource Utilization Group (RUG - institutional cost) for the individual – ranges from \$63,349 for an individual with basic care needs to \$260,011 for an individual with heavy care needs, including ventilator	50% of reimbursement rate that would be paid for the same individual to receive services in a nursing facility – ranges from \$15,837 for an individual with basic care needs to \$42,174 for an individual with heavy care needs,	200% of cost of comparable institutional care (ICF/ID) – maximum of \$114,736.07	200% of cost of comparable institutional care (ICF/ID) – maximum of \$114,736.07	200% of cost of comparable institutional care (ICF/ID) – ranges from \$167,468 to \$305,877 depending on the individual's level of need.	\$17,000

Appendix 2

Medicaid Long-term Services and Supports Waiver Programs

Program Feature	STAR+PLUS	CBA: Community-Based Alternatives	MDCP: Medically Dependent Children Program	CLASS: Community Living Assistance and Support Services	DBMD: Deaf-Blind Multiple Disabilities	HCS: Home and Community-based Services	TxHmL: Texas Home Living
	care needs, including ventilator dependency	dependency	including ventilator dependency				
Provider Requirements							
Licensure/certification requirements Note: under the CDS option, the Consumer Directed Services Agency, a fiscal/ employer agent, does not need to be licensed but must meet DADS training and contracting requirements.	Must be licensed by DADS appropriate for service provided: home and community support services agency (HCSSA) or assisted living facility.	Must be licensed as HCSSA or assisted living facility	Must be licensed as HCSSA	Must be licensed as HCSSA	Must be licensed as HCSSA or assisted living facility	Must be certified by DADS Regulatory Services. HCS providers are statutorily exempt from HCSSA and assisted living facility licensure	Must be certified by DADS Regulatory Services. TxHmL providers are statutorily exempt from HCSSA licensure
Interest Lists							
Number of people on interest list (09/30/12)	11,056 (non-mandatory individuals who have requested CBA-like services but are not currently Medicaid eligible and therefore not enrolled in STAR+PLUS)	11,172	25,810	44,039	537	60,832	NA (draws from HCS interest list)
Longest time on interest list (09/30/12)	5-6 years	2-3 years	5-6 years	8-9 years	3-4 years	10-11 years	NA

Charge #6-CPS Caseworkers: *Evaluate the management structure and supervision of CPS caseworkers with an emphasis on rural areas. Identify any legislative changes that could assist the Department of Family and Protective Services in maximizing efficiency, quality casework and supervision, and caseworker retention. Identify legislative changes to improve the quality of care for children in CPS, including improving permanency.*

Section I: Background

Child Protective Services (CPS) is the state agency tasked with carrying out one of the state's most important responsibilities - protecting children from harm. Because of the importance of its mission, the state must continually work to ensure that CPS produces the highest quality of casework and achieves permanency for children in the system. To reach those goals, CPS must: maintain proper management structures, especially in the rural areas of the state; enlist the community to assist in achieving resolution in the best interest of the child; maintain a stable workforce; and maintain a response system that appropriately identifies and treats the needs of the families in the system.

Section II: Analysis

Part 1: Management Structure

Child Protective Services (CPS) provides statewide protective, family support, and family preservation services to address child abuse and neglect.¹ CPS provides three broad categories, or stages, of services - investigations, family based safety services, and conservatorship services. A CPS *investigation caseworker* investigates reports of child abuse and neglect and, among other things, determines whether ongoing services are necessary to ensure a child's safety. If ongoing services are necessary, when possible, a CPS *family based safety services (FBSS) caseworker* assists in providing services to keep the child safe with the parent retaining legal custody. In some cases, however, removal from the home is the only way to protect the child. In those cases, a *conservatorship caseworker* seeks legal custody and provides conservatorship services.

CPS has always organized its caseworkers into units that cover specified geographic areas and report to a supervisor. Prior to 2004, there was some variation around the state in how the units were structured. In some urban areas, the caseworkers and supervisor worked together in units specializing in only one stage of service, such as investigations. Such units are known as *functional units*. In other areas, usually rural areas, the units were more general such that investigative and FBSS caseworkers may have reported to the same supervisor.

In 2005, the Legislature significantly reformed the CPS system by enacting Senate Bill 6, authored by Senator Nelson. As a result of those reforms, CPS expanded the functional unit structure that had been used in some urban areas *statewide*. Under this functional unit structure, all the caseworkers in a unit, along with their supervisor, specialized in one of the three stages of service - investigations, FBSS, or conservatorship services.

Benefits to a Functional Unit Structure

- Caseworkers and supervisors specialize in a particular stage of service, thereby developing the depth of knowledge and expertise necessary to provide quality casework.
- Training provides caseworkers and supervisors with both a general overview of all stages of service and specialized training allowing for a deeper study of the complex issues inherent in each particular stage of service.
- There is a fundamental difference in investigating a family for child abuse and neglect and providing services to ameliorate it. For example, because of the nature of an investigation, there may be an adversarial relationship between investigative caseworkers and a family under investigation. If that case is placed either in FBSS or conservatorship, a functional unit structure allows for a new caseworker to work with the family in a less adversarial manner. If the investigation caseworker were to continue working with a family once the case left investigations, the adversarial relationship could impede the process.

Rural vs. Urban

Although there are several benefits to the statewide functional unit structure, functional units present challenges in certain rural areas of the state. In rural areas, there are fewer caseworkers assigned to larger geographical regions. Therefore, a functional unit must be spread across several offices that are sometimes many miles apart. This leaves caseworkers with limited face-to-face interaction with supervisors or even other caseworkers in their unit. The lack of interaction can cause caseworkers to feel isolated and unsupported. Additionally, because of the distances between offices, supervisors and clerical staff expend significant amounts of time and money traveling between caseworkers.

Waiver from Functional Unit Structure

Recognizing that the functional unit structure may not be workable in some rural areas of the state, CPS created a "waiver" process that allows any Regional Director to request a change in the unit structure to include caseworkers from different stages of service. Regional Directors have taken advantage of this option such that, currently, there are 18 "mixed" units in different areas across the state. The 18 mixed units predominantly combine investigative and FBSS caseworkers, with one unit combining caseworkers from all three stages of service. In these mixed units, caseworkers remain specialized and provide only one type or stage of service, but they all report to one supervisor with expertise in all the stages. Table 1 below shows the regions with mixed units, the number of mixed units per regions, and the stages of service included.

Table 1. Units with More Than One Stage of Service by Region

Stage of Service included in mixed units	Region 2 (Abilene)	Region 4/5 (Tyler/Beaumont)	Region 7 (Austin)	Region 8 (San Antonio)	Region 9 (Midland)	Region 10 (El Paso)
	# of mixed units: 4	# of mixed units: 6	# of mixed units: 1	# of mixed units: 3	# of mixed units: 3	# of mixed units: 1
Investigations	X	X	X	X	X	X
Family Based Safety Services	X	X	X	X	X	X
Conservatorship						X

Strengthen Waiver Process

Although a waiver process exists, stakeholders have expressed concern that many caseworkers are not aware that a waiver process exists. Additionally, because the requests must come from Regional Directors, individual caseworkers who are experiencing negative consequences from the functional unit structure may choose to leave the agency rather than work through the chain of command in pursuit of a waiver.

To address these issues, the waiver process should be strengthened to ensure each region is designed in the most appropriate manner possible. CPS should increase outreach to caseworkers and supervisors, particularly in the rural areas, to educate staff on the existence of the waiver and the process to apply. Additionally, the executive team of CPS should proactively evaluate rural areas of the state and determine if a waiver could help address any workforce issues, such as recruitment or retention, for a particular unit or region. The combination of a top-down and bottom-up approach will ensure the waiver process successfully fulfills its purpose.

Tools Available to Address Rural Issues

CPS has been working over the last several years to transition to a more mobile workforce. Although implemented statewide, the mobile environment has been particularly useful in maintaining the caseworker-supervisor relationship in the rural areas of the state. The training and tools include:

- training for all supervisors of mobile units, including how to maintain unit cohesion;
- tablets for caseworkers and laptops for supervisors, which include the capability to connect to the internet and the DFPS intranet, so staff can communicate and have continual access to their e-mails, the DFPS case management system (IMPACT), and other internal applications that support their work;
- online meeting tools which allow videoconferencing so staff can attend meetings regardless of their physical location. CPS currently uses GoToMeeting and WebEx for these purposes. It does not use Skype because internet-based applications are vulnerable to hacking and viruses;
- digital cameras so staff can photograph investigation, inspection, and other case-related activities and e-mail them to supervisors if immediate consultation is needed; and
- state-issued cell phones.

Part 2: The Community Approach

The mission of The Texas Department of Family and Protective Services is to protect children, the elderly, and people with disabilities from abuse, neglect, and exploitation by involving clients, families, and communities.

CPS is supported in its mission to protect vulnerable populations by a network of community support systems, including law enforcement, judges, attorneys ad litem, Court Appointed Special Advocates (CASA), Child Advocacy Centers, teachers, and churches. To be successful, communities must work together in a cooperative and transparent manner with the primary goal of creating a system that is in the best interest of the child. Efforts must be made to prevent competing agendas that impede the ability of communities to protect children.

To ensure that community partnerships can effectively support victims of abuse and neglect, some advocates have called for expanded access to IMPACT (Information Management Protecting Adults and Children in Texas). This is the case management database system used by CPS to document all activities related to each case. Currently, CPS is the only entity authorized to input or access data.

Members of the community, such as CASA, attorneys ad litem, and judges, already have the legal authority to view much of the data included in the IMPACT system. However, to currently access the data, the individual typically must contact the CPS caseworker to either gather the information or gain access to the written file. This process is time consuming for all parties involved and creates a lag in the timeliness of information. By opening up access to the electronic database, relevant parties could access documents that would normally be shared via paper or verbal communication, such as: case plans, relative search information, assessment recommendations, visitation schedules, and medical and educational information on each child in foster care. This system would more quickly disseminate information, relieve the caseworker of certain administrative duties, and promote a collaborative approach to each case.

Because the database contains extremely sensitive information, no expansion to IMPACT should be undertaken unless confidentiality can be guaranteed. Access should only be granted in "tiers" such that interested parties only have access to relevant cases and authorized data.

One example of such a system is the Court Process Reporting System (CPRS) in Georgia. CPRS is a computer system that allows judges, attorneys, clerks, CASA, and other community leaders to share data in real time. Additionally, the non-CPS parties may also share data in the system such as court orders and CASA reports for all parties to view. The database is updated daily and allows access to data 24 hours a day and 7 days a week, increasing the communities access. This more efficient system frees up valuable time for all parties, thereby allowing additional time to devote to improving casework.²

Part 3: Maximizing Efficiency, Quality Casework and Supervision, and Caseworker Retention

The Turnover Cycle

CPS must maintain a stable workforce to ensure it successfully meets its responsibilities. To achieve a stable workforce, CPS must effectively retain and recruit quality caseworkers.

Retention

Caseworker turnover can create a downward spiral with far reaching consequences for every stage of service delivery at CPS. Identifying the various aspects of turnover is critical in developing a response to stabilize the workforce.

When turnover occurs, it creates a strain on the entire system. Once a caseworker leaves CPS, their caseload is redistributed among the remaining staff, thereby adding to their already high caseloads and stress levels. The increased caseloads lead to higher delinquency rates in investigations and slower rates of resolution across the system. As a result, investigation quality suffers, child safety could be jeopardized, and staff experience increasing levels of stress. This leads to even greater turnover, starting the cycle over once again.

Figure 1. The Turnover Cycle



CPS caseworker statewide turnover for 2012 reached 26.1%. Turnover is even higher in certain regions of the state, such as the Midland/Odessa area where turnover has reached 29.3% in 2012, up from 28.1% in 2011.³

Breaking the Turnover Cycle

In order to break the turnover cycle, CPS must focus on recruiting and retaining a sufficient workforce. CPS' ability to recruit and retain caseworkers and supervisors will stabilize the workforce and result in adequate caseloads, which will produce better quality casework. Improved quality will thereby lower stress and increase job satisfaction, thereby improving recruiting and retention.

Figure 2. Stabilizing the Workforce



Getting There - Stabilizing the Workforce and Workload

To better retain caseworkers, the state must address the primary reasons for caseworkers leaving CPS employment.

According to a 2012 State Auditor's Office Exit Survey of former caseworkers and supervisors, staff identified the following reasons for leaving:

- (1) working environment (23.5%);
- (2) retirement (16.2%);
- (3) compensation (13.2%);
- (4) caseworker-supervisor relationship (12.9%);
- (5) no or little career advancement opportunities (6.3%);
- (6) personal or family health (5.1%);
- (7) relocation (5.1%); and
- (8) other reasons (17.8%).⁴

To reduce turnover, CPS must work to address the following issues:

1. Work Environment

High workloads create an atmosphere that breeds high levels of stress and overloads caseworkers. CPS must create a positive work environment to reduce caseworker stress and increase workforce satisfaction to assist in decreasing turnover. To achieve such a result, the state has several tools available for consideration:

- maintain an adequate workload;
- hire ahead for caseworkers;
- streamline administrative tasks;
- identify and replicate best practices;
- strengthen mentoring and recognition programs; and
- allow flexible schedules.

Maintain an Adequate Workload

In the months leading up to the 2005 legislative session, CPS caseloads were at the levels described in Table 2.

Table 2. CPS Average Daily Caseloads for Fiscal Year (FY) 2005⁵

Average Daily Caseloads	FY 2005
Investigation	41.1
Family Based Safety Services	19.4
Conservatorship	37.3

After the Legislature approved Senate Bill 6 and additional funding in 2005, caseloads declined. Although the average daily caseloads have fluctuated for the past several years, there has been a general trend of decreased average daily caseloads over the last two biennia in investigations and FBSS caseloads. A slight increase has occurred in conservatorship caseloads. These averages are described in Table 3.

Table 3. CPS Average Daily Caseloads for FY 2010-13⁶

Average Daily Caseloads	FY 2010	FY 2011	FY 2012	FY 2013
Investigation	29.1	27.4	24.6	21.6
Family Based Safety Services	21.9	16.9	14.3	13.7
Conservatorship	29.5	32	33.7	33.4

It is important to note that average daily caseloads do not provide a complete picture of workload across the state. Due to local factors such as turnover, vacancy rates, and the number of new workers in training, specific regions and individuals may experience much higher or lower caseloads than the statewide average. For example, as of September 2012, the investigation average daily caseload was 21.6 statewide, but 33.2 for Fort Bend County and 17.6 for Tarrant County.⁷

The state should continue to closely monitor workloads to ensure that the average daily caseloads are adequate for quality casework. Further, CPS should closely monitor regional and individual caseloads across the state to ensure that work is distributed as evenly as possible.

Hire Ahead for Caseworkers

It is important to focus not only on retention, but also on recruitment of qualified caseworkers. Recruitment plays an essential role in breaking the turnover cycle. It is not enough for the Legislature to appropriate funding for hiring caseworkers if CPS is not actively recruiting and hiring caseworkers to fill the appropriated positions. It is important to note that CPS has yet to fill all the positions the Legislature appropriated in the 82nd Legislative Session (see Table 4).

Table 4. Average Monthly CPS Caseworker FTEs for FY 2012-13⁸

Average Monthly CPS Caseworker FTEs	FY 2012	FY 2013 (year to date)
Appropriated by the Legislature	4,956.5	4,956.5
Actually Filled by DFPS	4,551.7	4,670.7
<i>Appropriated, but Not Filled</i>	404.8	285.8

To maintain a sufficient workforce to adequately manage incoming cases, CPS should ensure that the level of caseworkers remains stable, taking into account normal turnover and retention trends. Due to high caseworker turnover, CPS should recruit and hire ahead for caseworker positions, taking into account the time needed for training before a caseworker is assigned a full caseload. In the event that CPS makes any decisions to substantially slow the pace of hiring efforts for any reason (e.g., a reorganization or hiring freeze), it should formally notify legislative leadership before moving forward with any changes.

Streamline Administrative Tasks

Paperwork at CPS can be overly burdensome and duplicative, diverting time caseworkers could spend working directly with clients. Streamlining paperwork and forms required by state statute or CPS policy would greatly improve efficiency and quality of casework.

DFPS completed a Contact Documentation Efficiency Assessment in August 2012. Recommendations from this assessment include establishing documentation standards and developing a technology strategy that addresses the long-term goals for DFPS' electronic systems.⁹ DFPS should evaluate and begin to implement the recommendations of this assessment in order to streamline the paperwork process and adapt technology to maximize casework efficiency and quality.

Creating a community accessible database as described in Part 2 would also assist in streamlining administrative tasks for caseworkers.

Identify and Replicate Best Practices

CPS should identify best practices of units or individual caseworkers who successfully manage paperwork and other job requirements. The agency should find ways to implement these best practices among other units and caseworkers.

For example, Child Advocacy Centers (CACs) allow for co-location of CPS caseworkers at CACs, which advocates believe fosters a better work environment because key players (e.g., law enforcement, prosecutors) are working together in close proximity. CPS should explore better utilizing co-location and evaluate how to implement best practices from co-location.

Strengthen Mentoring and Recognition Program

CPS can positively impact the work environment by providing a structured mentoring program for caseworkers and supervisors. CPS can also boost job satisfaction by expanding its caseworker recognition program.

Allow Flexible Schedules

Caseworkers report that Fridays and Mondays are especially hectic because of an influx of last minute reports before the weekend and the queue of calls that come in over the weekend. This can disrupt a caseworker's normal workflow. CPS should explore the possibility of allowing caseworkers to work in more flexible shifts to spread out coverage over the weekend and during the week. Flexible schedules could potentially ease the stress of Friday and Monday workloads and provide a more stable work week.

2. Supervisor Relationship

Supervisors play an important role in creating a positive work environment by supplying guidance and support for caseworkers. A strong caseworker-supervisor relationship factors heavily in job satisfaction, thereby decreasing turnover and playing a critical role in maintaining manageable workloads. CPS can improve caseworker-supervisor relationships by:

- maintaining adequate caseworker-to-supervisor ratios;
- training supervisors prior to placement; and
- involving supervisors in the caseworker hiring process.

Maintain Adequate Supervisor to Caseworker Ratios

In the 79th Legislative Session, SB 6¹⁰ lowered caseworker-to-supervisor ratios to 1:5 for investigations, conservatorship, and FBSS. Over time, those ratios have grown to 1:6 for investigations and 1:7 for both conservatorship and FBSS. At this time, CPS is recommending to reduce the supervisor span of control to 1:5 for investigations, 1:6 for conservatorship, and maintaining a ratio of 1:7 in FBSS. This request is included in DFPS' FY 2014-15 Legislative Appropriations Request.¹¹

CPS should ensure caseworker-to-supervisor ratios are appropriate. In addition, CPS should constantly examine and re-evaluate its workforce to determine if certain supervisors can take on additional workers, depending upon experience and ability. CPS could allow for a flexible caseworkers-to-supervisor ratio that is appropriate to circumstances and supervisor capability.

Training Supervisors Prior to Placement

Supervisors must be adequately equipped and prepared for their managerial role within CPS. Although CPS currently requires specific training for supervisors, no training is required *before*

the supervisor begins their managerial role. New supervisors have 60 days after starting as a manager to complete the required training. CPS should consider requiring new supervisors to complete this training prior to assuming their managerial role. Sixty days is a significant amount of time and it is important that supervisors are prepared for their new role at the outset so that they can be effective leaders and guide caseworkers appropriately, ultimately enhancing the caseworker-supervisor relationship.

Involving Supervisors in the Caseworker Hiring Process

CPS should continue to involve supervisors in the hiring process to ensure that new hires are a good fit for the team and will work well with the supervisor and other caseworkers.

3. Compensation

While pay is not the only factor in caseworker recruitment and retention, it is an important consideration. In addition to reviewing salary levels, possible incentives include:

- merit-based raises;
- opportunities for advancement; and
- monetary incentives for caseworkers to become supervisors.

Merit-Based Raises

Recognizing high quality casework with financial incentives can serve as a valuable tool in reducing turnover. CPS should strategically plan distribution of merit-based raises for time intervals in which caseworkers are known to leave CPS. These efforts have the potential to attract quality staff and reduce turnover, resulting in improved quality of casework due to a more stable workforce.

Opportunities for Advancement

In order to incentivize quality work and caseworker investment, CPS should ensure that there is suitable room for career growth as a caseworker. Currently, after a caseworker becomes a Caseworker IV, there is no opportunity for a pay raise unless a caseworker becomes a supervisor. Extending the career ladder for a caseworker would reward and retain experienced caseworkers and encourage newer caseworkers to stay with CPS.

Monetary Incentives for Caseworkers to Become Supervisors

Moreover, CPS should create incentives for capable caseworkers to become supervisors. Currently, as a supervisor, the increase in pay is nominal, but the increase in stress and responsibility is sizeable. DFPS has requested an exceptional item in its FY 2014-15 Legislative Appropriations Request to raise the supervisor salary schedule.¹² Experienced caseworkers can provide institutional knowledge and skills when promoted to supervisor.

Part 4 - Differential Response

The concept of child abuse was originally thought to include physical and sexual abuse. The primary purpose was to determine whether the abuse occurred and who perpetrated it so the system knew who to protect the child from.

With the drug epidemic in the 1980's, however, a new type of case emerged where the threat came primarily from the parent's chronic inability to safely care for the child rather than a deliberately harmful act. These cases were generally categorized as neglect as opposed to abuse. In 2011 in Texas, 63% of the confirmed allegations were for neglectful supervision while physical abuse and sexual abuse represented 16% and 8%, respectively.¹³

Both abuse and neglect threaten a child's safety, however the more forensic investigative approach developed for abuse cases is not necessarily as useful or appropriate in a neglect case. In most neglect cases, rather than identify a perpetrator, caseworkers should focus more heavily on assessing how to help a family safely care for their child.

A New Approach

A differential response system (also known as alternative response) allows for at least two different response tracks. Both tracks involve an assessment of safety, risks to the child, and needed services to support the family. The difference lies in what is included in the assessment and how it is conducted. High risk, serious cases such as physical and sexual abuse follow a traditional investigative track, which includes a formal finding about whether abuse occurred and identifies a perpetrator. As with the current process, once a perpetrator is identified, they become part of the central registry with all the attendant administrative remedies and associated costs.

Cases that do not involve an immediate safety risk, but which require intervention, usually follow an alternative, less adversarial track. The assessment does not include a formal finding of abuse or neglect or the designation of a perpetrator. By eliminating the focus on fault finding in low-risk cases, parents can be more open and engaged and caseworkers can focus their efforts on resources to strengthen family functioning.

Benefits of the Differential Response

Studies from states that have implemented a differential response process show that families on the alternative track feel more engaged and involved with decisions made about their children. Caseworkers have reported that families on the alternative track were more cooperative and willing to accept services.

Studies also indicate that a differential response system often results in cost-savings. Since there is no formal finding of abuse or neglect or designation of a perpetrator in a case following the alternative track, costly and time consuming administrative reviews and hearings are eliminated from these cases. Moreover, studies show that states with a differential response system reduce costs over time because families following the alternative track are less likely to have subsequent reports or investigations.¹⁴

Current Status of Investigative Responses in Texas

In 2011, Congress amended the Child Abuse Protection and Treatment Act (CAPTA), mandating that all states receiving CAPTA funding have some type of differential response process in place by September 1, 2011.

Texas presently meets the CAPTA requirements through its investigative screening process, which was originally implemented in 2006. Currently, there are two different tracks a report can follow after it is referred to CPS from statewide intake. Cases involving serious abuse allegations or young children are immediately referred for a traditional investigation while less serious reports involving older children are referred for a formal screening. With a formal screening, trained screeners conduct a preliminary investigation on a case. Based on the information they gather, if the case does not meet the criteria to warrant a traditional investigation, the screener refers the family to community resources if available and then closes the case without an investigation. Otherwise, the screener refers the case to be assigned for a traditional investigation.¹⁵

Expanded Implementation

The 83rd Legislature should explore the concept of expanding the state's alternative response system.

As part of its review, serious abuse cases that do not meet the criteria for an initial formal screening should continue to be referred for a traditional investigation that follows all of the current policies and procedures. However, for cases that are eligible to be screened, cases meeting certain criteria could be referred to an alternative investigation, with all other cases referred to a traditional investigation.

Like those on the investigative track, those referred to an alternative investigation should have a home visit, a safety and family assessment, and if appropriate, service planning and ongoing CPS involvement to ensure the safety of children.

Cases should be moved between tracks if circumstances change. If a caseworker conducting an alternative investigation determines that the case is more serious than originally identified or there is an imminent safety threat to the child such that the case no longer meets the alternative track criteria, there should be a process to refer the case for a traditional investigation.

Section III: Conclusion

By utilizing proper management structures, enlisting the assistance of the community, maintaining a stable workforce, and expanding the state's response system, CPS will ensure the highest quality of casework and permanency for the children of this state.

Section IV: Recommendation

- **CPS should increase awareness about its functional unit waiver process.**
- **CPS should build strong community partnerships and explore tiered access to IMPACT data if confidentiality can be assured.**
- **CPS should maintain a stable workforce by addressing turnover issues affecting retention and recruitment.**
- **CPS should explore expanding the state's alternative response system.**

¹ Texas Human Resources Code §40.002(b)(1) and (2).

² See Georgia CPRS Court Process Reporting System Homepage, <http://gacprs.org/> (Last accessed December 4, 2012).

³ See Rider 25 (82nd Texas Legislature) Foster Care Redesign Report, p. 3, http://www.dfps.state.tx.us/About_DFPS/Legislative_Presentations/DFPS/rider.asp (Last accessed December 4, 2012).

⁴ Texas State Auditor's Office State of Texas Employee Exit Survey Aggregate Results: Agency 530: Department of Family and Protective Services Fiscal Year 2012, 9/1/2011 to 8/31/2012.

⁵ Department of Family and Protective Services Dashboard November 2012.

⁶ *Id.*

⁷ Department of Family and Protective Services, Legislative Briefing, Austin, Texas, November, 12th, 2012.

⁸ Department of Family and Protective Services Dashboard September and November 2012.

⁹ Information Provided by Department of Family and Protective Services to staff via email November 2nd, 2012.

¹⁰ Senate Bill 6 by Senator Jane Nelson passed by the 79th Legislature.

¹¹ See Department Family and Protective Services Legislative Appropriations Request, FY 2014-15.

¹² *Id.*

¹³ Information provided by Department of Family and Protective Services staff via email, November 20th, 2012.

¹⁴ *Id.*

¹⁵ *Id.*

Charge # 7- Public Health: *Examine the delivery and financing of public health services in our state, including how federal funds are distributed by the state to local health departments and whether the work done by Regional Health Departments operated by the Department of State Health Services overlap unnecessarily with local health departments.*

Section I: Background

Public health services in Texas are provided through a combination of Local Health Departments (LHDs) and Health Service Region Headquarter offices (herein referred to as 'Regional Health Departments' or RHDs) located throughout the state. The Texas Department of State Health Services (DSHS) determines and promotes statewide public health policy priorities, serves as the liaison between federal, regional and local public health entities, oversees and staffs RHDs, and performs administrative, epidemiological, contract management, program compliance, and quality assurance functions within the public health delivery system.

Local Health Departments

Established by city councils or commissioner's courts, LHDs are designated as the provider of essential public health services. There are 61 full service LHDs in Texas, meaning that they provide all of the following ten essential public health services identified in state statute:

1. Monitor the health status of individuals in the community to identify community health problems;
2. Diagnose and investigate community health problems and community health hazards;
3. Inform, educate, and empower the community with respect to health issues;
4. Mobilize community partnerships in identifying and solving community health problems;
5. Develop policies and plans that support individual and community efforts to improve health;
6. Enforce laws and rules that protect the public health and ensure safety in accordance with those laws and rules;
7. Link individuals who have a need for community and personal health services to appropriate community and private providers;
8. Ensure a competent workforce for the provision of essential public health services;
9. Research new insights and innovative solutions to community health problems; and
10. Evaluate the effectiveness, accessibility, and quality of personal and population-based health services in a community.¹

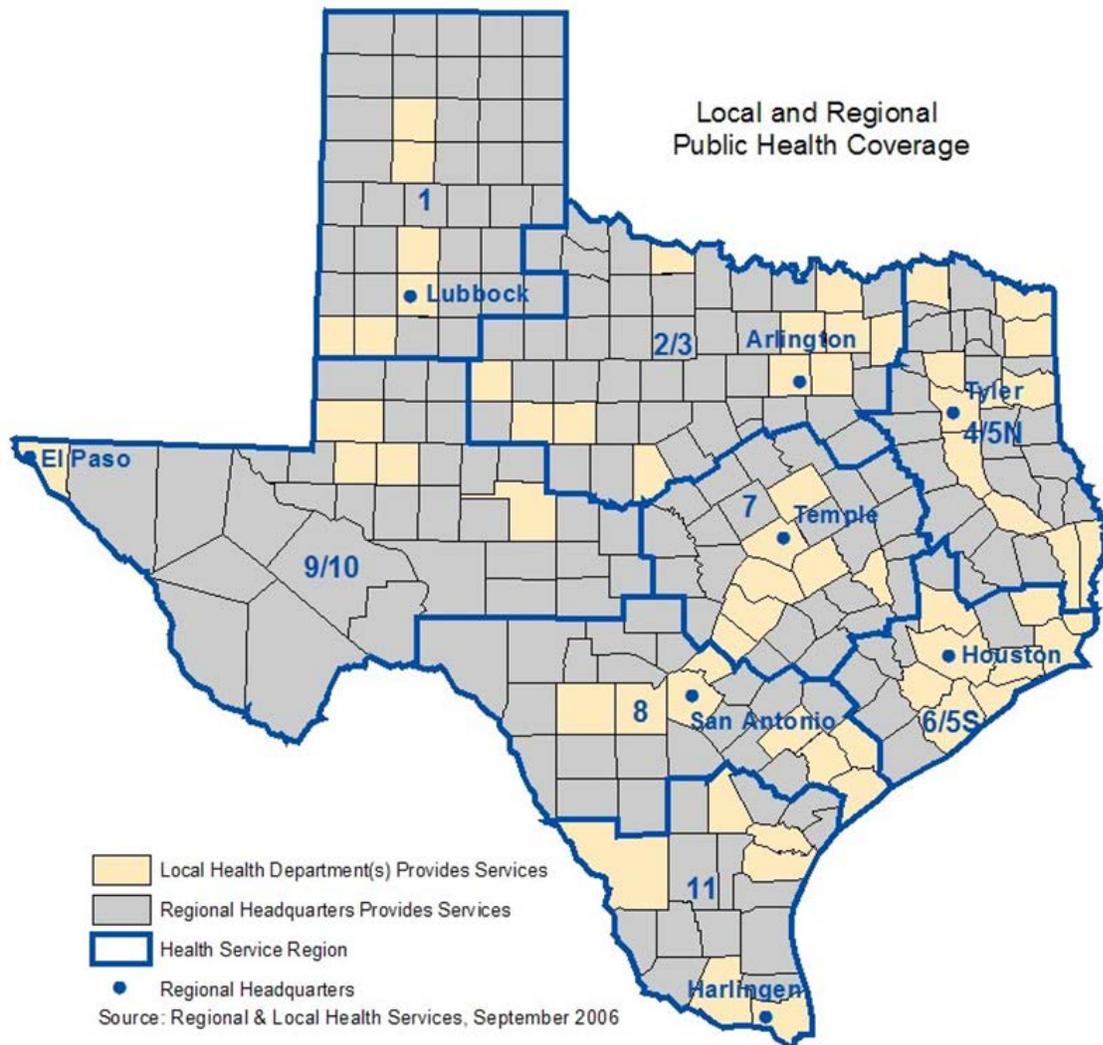
More specifically, LHDs provide disease prevention, surveillance, epidemiology, and control in order to maximize immunization rates, prepare for and respond to disasters and outbreaks, monitor and control Tuberculosis (TB), engage in public education about and prevention of chronic diseases, and prevent and treat HIV/AIDS and sexually-transmitted diseases (STDs).

Regional Health Departments

The state of Texas is divided into eight Health Service Regions that are each served by a single RHD (shown in Figure 1), staffed and overseen by DSHS.² In addition to providing essential public health services in areas where there is no LHD or the existing LHD does not offer all essential public health services, there are some services that are exclusively performed by RHDs.

These include zoonosis control, environmental health services, maintenance of statewide health registries, school-based health screening programs, food and drug safety, radiation control services, and consumer safety activities. These services are described in more detail on page 10.³

Figure 1. Distribution of Regional and Local Health Departments



Section II: Analysis

Part One: Current Public Health Funding and Delivery System in Texas

The majority of funding for public health services comes from the federal government and is allocated to DSHS through cooperative agreements. Funding flows to the state in a variety of funding streams dedicated to specific public health functions, such as immunizations, disaster preparedness, TB control and prevention, and HIV/AIDS and STD prevention, surveillance and

treatment. Both LHDs and RHDs also receive state General Revenue (GR) to perform public health services.

Federal and state funding is allocated from DSHS to LHDs through annual contracts for each of the major public health functions listed above. These contracts come with many reporting and compliance requirements. In contrast to the LHD contracting system, RHDs are not required to contract with DSHS for funding and therefore are not subject to the same reporting and compliance requirements. Federal and state funding is allocated from DSHS to RHDs on an annual basis for the major public health functions listed above, as well as for completion of the public health functions performed exclusively by RHDs, which are described on page 10.⁴

In addition to federal and state GR funding, some LHDs receive funding from their local county or municipality. The amount of federal, state and local funding for LHDs and RHDs that flows through DSHS is depicted in Figure 2.

Figure 2. FY 2012 Funding Sources for LHDs and RHDs,

	Federal Funding^{5, 6}	General Revenue⁷	Local Funding⁸
Local Health Departments	\$168 million	\$39.9million	\$209.5 million
Regional Health Departments	\$24.6 million	\$32.8 million	N/A

Funding for Public Health Services

The major areas of public health funding for LHDs and RHDs are immunizations, preparedness, TB, prevention, and HIV/AIDS and STDs. The method by which federal funding flows to the state in each of these areas, and the way in which federal and state funds flow to LHDs and RHDs, varies by public health category. Prior to considering significant changes to the way these funds are allocated, it is important to understand the complexities of the current system.

Local Health Departments: LHDs generally receive a combination of federal and state funding for all of the major categories of public health services, although some LHDs receive only federal or only state funding for specific areas of public health.⁹ Typically, federal and state funding is combined within contracts, but in some areas such as TB prevention and control, funding to LHDs is allocated through separate federal and state contracts. In addition to these contracts, most LHDs also receive a separate GR-funded contract from their local RHD to support salaries that are not supported by local or federal funding.¹⁰

Regional Health Departments: RHDs generally receive a combination of federal and state funding from DSHS for the major public health functions (immunizations, preparedness, TB, prevention, HIV/AIDS and STDs), although some RHDs receive only federal or only state funding for some of these activities. RHDs also receive state GR and GR-Dedicated funding to provide RHD-specific services such as zoonosis control, environmental health services, and other activities listed on page 2. Funding for RHDs is not allocated through contracts, since RHDs are part of the DSHS agency. The majority of RHD funding is allocated based on

historical funding levels, although preparedness and some TB funding is allocated using funding formulas.¹¹

Immunizations:

Federal Funding: Federal Funding for immunization activities comes to DSHS from the Centers for Disease Control and Prevention (CDC) through the Immunization Infrastructure Grant. This grant supports the following activities:

- Administration of the following federal immunization programs:
 - *Vaccines for Children (VFC) Program:* The VFC Program is an entitlement program that provides free vaccines for children who are uninsured, Medicaid-eligible, Alaskan Native or American Indian, or underinsured (only if served in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic). The program covers all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the CDC.¹²
 - *Section 317 Immunization Program:* The Section 317 program is a discretionary program that relies on annual appropriations from Congress. In Texas it funds immunization operational activities and vaccines for underinsured children and adolescents not served by the VFC program as well as some adults.
- Recruitment of providers for the VFC program and the DSHS adult safety net immunization program, which provides vaccines to vulnerable individuals not covered by federal VFC program funds, such as the elderly;^{13,14}
- Quality assurance efforts to ensure that providers who receive vaccines through the VFC and adult safety net immunization programs effectively manage and administer immunizations;
- Operation of ImmTrac, the statewide immunization registry;
- Management of the state's federal allotment of vaccines; and
- Public education and outreach campaigns aimed at increasing immunization levels.¹⁵

Actual vaccine doses for federal immunization programs are held by the CDC on behalf of the state and shipped directly to enrolled providers, including LHDs, based on monthly orders submitted by DSHS. The value of this vaccine allotment is not included in the state budget, since funding for these vaccines does not actually flow through the state. Vaccine doses for the adult safety net immunization program, funded by both state and federal Section 317 dollars, are shipped to providers, including LHDs, either by the CDC or by the state pharmacy.¹⁶

State Funding: GR funding is used to supplement federal funding that supports immunization operations, programs for underinsured children, education and recruitment of providers for immunization programs, and the operation of ImmTrac. GR funding is also used to purchase vaccines for Texas' adult safety net immunization program.¹⁷

Distribution of Immunization Funding to LHDs: LHD contracts for immunization activities combine federal and state funding. Contract amounts are based on a formula that depends on the population density of children ages 0 through 18 years in the LHD's service area as well as the number of active providers participating in the VFC Program in the LHD's service area. These

factors reflect the level of effort on the part of the LHD to maintain a safety net immunization provider network.¹⁸

Only 50 of the state's 61 full-service LHDs choose to contract with the state to receive federal Immunization Infrastructure Grant funding, although all 61 full-service LHDs are enrolled as VFC providers and therefore receive regular allocations of vaccines from the state's share held by the CDC. The 11 LHDs who choose *not* to contract with the state for these services rely on the RHDs in their region to provide immunization management services.¹⁹

Distribution of Immunization Funding to RHDs: DSHS allocates federal Immunization Infrastructure Grant funding as well as state GR funding for immunization activities to RHDs based on historical funding levels. In addition to managing the federal VFC and Section 317 Programs, RHDs also use their funding allocations to manage the adult safety net immunization program and recruit providers to participate in the ImmTrac registry, the VFC Program, and the adult safety net immunization program.²⁰

Preparedness: Preparedness funding ensures that LHDs are prepared for and adequately respond to public health disasters such as natural disasters, infectious disease outbreaks, chemical and biological attacks, and food-borne illness outbreaks. RHDs utilize preparedness funding to coordinate large-scale (sometimes multi-state) disease outbreak investigation and response activities, evacuations, and the deployment of state assets such as pharmaceuticals and medical equipment during disasters.²¹

Federal Funding: Federal funding for public health preparedness activities comes to the state from the CDC through the Public Health Emergency Preparedness (PHEP) cooperative agreement with DSHS.²²

State Funding: There is currently no state funding for preparedness activities.

Distribution of Preparedness Funding to LHDs: Since there is no state funding for preparedness activities, LHD contracts for these activities only contain federal PHEP funding. Through these contracts with DSHS, each LHD receives a \$20,000 base allocation plus a per capita allocation, which fluctuates depending on the level of federal funding received by the state. Until FY 2013, when an 8% increase in federal funding allowed DSHS to establish a \$100,000 minimum allocation per LHD, the lowest annual amount received by a LHD for annual preparedness funding was \$39,000. The agency used the remainder of the 8% increase in FY 2013 to create a \$1 million competitive LHD discretionary fund for preparedness activities, and to maintain binational health surveillance activities at four border LHDs. Funding allocations to LHDs were originally intended to be based on population, but due to fluctuations in federal funding (all LHDs sustained significant across-the-board cuts between FY 2008-2012, followed by the 8% increase for FY 2013), allocations are now based primarily on historical funding levels, rather than on population.²³

Outside of these contracts, there are some additional allocations of federal preparedness funding that apply only to select LHDs:

- In FY 2013, the two largest LHDs in the state, the Dallas County Department of Health and Human Services and the City of Houston Department of Health and Human Services, were among 10 U.S. cities to receive an additional federal PHEP 'high risk' allocation for preparedness activities based on the higher risk they face for biological, chemical, and terrorist attacks. This was a one-time allocation that these LHDs are allowed to carry forward to the next Fiscal Year if they do not expend all of the high risk allocation in FY 2013.²⁴
- A separate PHEP allocation (\$1.1 million total in FY 2013) is provided by DSHS to six LHDs to operate the Laboratory Response Network (LRN), a network of six LHD labs equipped to respond quickly to acts of chemical or biological terrorism, emerging infectious diseases, and other public health threats and emergencies.²⁵

Distribution of Preparedness Funding to RHDs: DSHS allocates federal preparedness (PHEP) funding to RHDs based on the same funding formula used to determine LHD preparedness contract amounts: each RHD receives a \$20,000 base allocation plus a per capita allocation, which fluctuates depending on the level of federal funding received by the state. RHDs have been subject to the same significant federal across-the-board PHEP cuts as LHDs over the past several years. Additionally, RHDs received only 13% of the total FY 2013 8% increase in PHEP funding.²⁶

Tuberculosis (TB): Federal and state TB funds allow LHDs and RHDs to prevent, control, and treat outbreaks of TB. Although the number of reported TB cases in Texas has continued to decline over the past several decades, the number of TB cases reported annually in Texas remains one of the highest in the country, and the TB mortality rate has remained significantly higher than the national average. Texas' location along the Mexico border presents significant challenges to the state, with a TB incidence rate along the border of 9.9 cases per 100,000 population in comparison to 4.9 cases per 100,000 population in non-border areas.²⁷

Federal Funding: Federal funding to detect, treat, and control the spread of TB comes to DSHS from the CDC based on a formula that takes into account the number of active TB cases in the state, as well as historical funding levels.²⁸

State Funding: GR funds are used to provide in-kind support to LHDs such as TB medications, testing supplies, and laboratory analysis to LHDs located in areas where morbidity is too low to result in grant funding (grant funding criteria described below). GR funding also supports RHD efforts to provide chest radiography, physician services, and directly-observed therapy in areas with low TB morbidity.

Distribution of TB Funding to LHDs: The majority of funding for TB prevention, surveillance and control is provided to LHDs through contracts with DSHS that combine federal and state funding. These contracts are entered into with LHDs who have had an average of at least 15 active cases of TB over the past five years. Currently, 14 LHDs meet this minimum morbidity requirement and therefore receive contracts. Until FY 2013, contract amounts were based on a

formula that includes eight weighted components:

1. Number of active TB cases in the LHD service area;
2. Number of active TB cases among special populations in the LHD service area (this includes children younger than five at diagnosis, US-born minorities, homeless individuals, foreign-born individuals, individuals with documented substance abuse disorders, residents that live along the US-Mexico border, and individuals with diabetes);
3. Number of multi-resistant TB cases;
4. Number of TB cases completing therapy;
5. Number of individuals co-infected with TB and HIV;
6. Number of individuals the LHD suspects but has not confirmed as having active TB;
7. Total population in the LHDs service area; and
8. Total square miles in the service area.

For FY 2013, DSHS provided level-funding (continued funding at FY 2012 levels) for the 14 LHDs that meet TB morbidity requirements rather than using the above funding formula to determine LHD contract amounts. Level-funding was used in FY 2013 because DSHS is conducting a broad-based TB strategic planning initiative across the state that includes a formal funding formula group to advise DSHS on recommended changes to the TB funding methodology for LHDs and RHDs. This initiative is discussed in Part Two of the Analysis of this report.

LHDs that do not meet the minimum TB morbidity requirements but still have a demonstrated TB disease burden may receive state funding from the RHD in their area to perform TB prevention and control activities, such as chest radiography, physician services, and directly-observed therapy. In some cases, the RHD provides these services rather than contracting with a LHD.

Distribution of TB Funding to RHDs: DSHS allocates federal and state funding for TB prevention, surveillance and control to RHDs. For FY 2013, DSHS provided level-funding (continued both GR and federal funding at FY 2012 levels) for all RHDs due to the current agency TB strategic planning initiative discussed above. Prior to FY 2013, each RHD received an annual base allocation of \$125,000 in GR funding. Any GR funding remaining after this \$125,000 base was met was allocated to RHDs based on the same eight-component funding formula that is used to allocate funding to LHDs (outlined above). Federal funds are typically allocated to RHDs based on historical funding levels.

Prevention

Funding for prevention activities at LHDs supports a variety of activities ranging from chronic disease prevention and public education programs, to providing nutrition services to families enrolled in the Women, Infants and Children (WIC) program. The source and level of federal and state funding for these activities varies across programs.

- *Chronic Disease Prevention and Treatment:*
 - Federal funding: Federal funds for preventing and treating chronic diseases come to DSHS from the CDC and support activities such as diabetes awareness and

- self-management, promoting healthy food choices, and expanding opportunities for physical activity in communities.
- State Funding: GR funding is used to support local efforts to reduce obesity rates and promote healthy lifestyle choices.
 - Distribution of Funding to LHDs: LHDs compete with other local entities such as cities, non-profit organizations, and institutions of higher education to receive chronic disease prevention grants. These grants may be completely federally funded, completely state (GR) funded, or include a combination of federal and state funds.
 - Distribution of Funding to RHDs: RHDs generally do not receive funding for chronic disease prevention, as these activities are typically performed at the local level. However, the few RHDs that do perform these activities receive federal funding from DSHS based on their disease burden in the specific area the grant in question is intended to address.²⁹
- *Tobacco Prevention and Control*
 - Federal Funding: Federal funding for tobacco prevention and control is used to support statewide programming such as Texas Tobacco-Free Kids Day activities, a statewide tobacco prevention conference for youth, and tobacco education classes for youth found in violation of state and federal tobacco laws. Federal funding also supports the use of Regional Tobacco Coordinators at several RHDs, who are supported by tobacco program staff at the DSHS Central Office. The Regional Tobacco Coordinators work with local community coalitions, foundations, non-profit organizations, work sites, health care providers, and other stakeholders in their respective regions to promote tobacco prevention and cessation.³⁰
 - State Funding: GR and GR-Dedicated funding for tobacco prevention and control supports community-based coalitions to implement evidence-based tobacco control, education, and cessation programs, particularly among children and youth. GR-Dedicated funding comes from the Tobacco Settlement Fund.
 - Distribution of Funding to LHDs: LHDs compete with other community-based organizations that receive federal and state funding to operate community-based tobacco prevention and cessation coalitions. Currently, five LHDs receive funding to operate these coalitions, and four of these five coalitions are funded entirely using state dollars, while one coalition receives a combination of state and federal funding.³¹
 - Distribution of Funding to RHDs: Federal and state funding for tobacco prevention and control is allocated to RHDs based on the region's population and geographic area.³²
 - *Women, Infants and Children*: The Women, Infants and Children (WIC) program is a federally-funded program that provides nutritious supplemental foods to low-income women and their young children.
 - Federal funding: In addition to providing supplemental food assistance, the WIC program also provides nutrition education, breastfeeding support, and referrals to healthcare providers. These elements of the WIC program are considered chronic disease prevention activities. Federal funding for these activities is allocated to

LHDs, as well as to cities, counties, hospital districts, hospitals, community action agencies, and other non-profit entities, through contracts.

- State Funding: Although the WIC program is federally funded, the DSHS Central Office uses state GR funding to support the administration of this program.
- Distribution of Funding to LHDs: DSHS contracts with some LHDs, as well as other local entities, to operate WIC Clinics. These Clinics provide WIC nutrition benefits, nutrition education, breastfeeding support, and referrals to healthcare providers using federal funding.
- Distribution of Funding to RHDs: Many RHDs operate WIC clinics using federal funding. They also receive state GR funding to support administration of the WIC program, including salaries.

HIV/STD Surveillance, Prevention and Treatment: RHDs and LHDs utilize federal and state funding to provide HIV/AIDS and STD prevention, surveillance, epidemiology, treatment, and support services.

Federal Funding: Federal funding for this area of public health services comes from a variety of sources:

- Health Resources and Services Administration (HRSA): Provides funding for the Ryan White HIV/AIDS Program, which provides medical care and treatment, as well as some support services. This funding goes primarily to hospital districts and other medical providers, rather than to RHDs or LHDs.
- CDC: Provides funding for HIV/AIDS and STD prevention including testing services and supplies. Also funds HIV/AIDS surveillance and epidemiology activities that provide data about the extent and trends of HIV infection and informs the development of prevention interventions.
- Department of Housing and Urban Development (HUD): Provides limited funding for supportive housing for low-income uninsured individuals with HIV/AIDS.
- Substance Abuse and Mental Health Services Administration (SAMHSA): Funds a special initiative in the Dallas area to assist individuals with co-occurring HIV and substance abuse or mental illness issues.³³

State Funding: GR funds are primarily used to supplement federal funding for prevention and treatment of both HIV/AIDS and STDs, as well as epidemiological surveillance of HIV/AIDS. A large amount of GR funding is used to operate the Texas HIV Medication Program, which provides access to HIV treatment medications to individuals who qualify for the program based on income and other eligibility requirements. A small amount of GR is allocated specifically to support the Education and Prevention Program for Hepatitis C, which monitors acute Hepatitis C virus infections and reduces viral hepatitis disease and deaths by providing education and guidance on prevention, control measures, and immunizations.³⁴

Distribution of HIV/AIDS and STD Funding to LHDs: Federal and state funding is allocated to LHDs through competitive grants or contracts with DSHS, depending on the intended use of those funds:

- Prevention Funding: LHDs compete with other local entities such as non-profit organizations and medical clinics to receive funding for the prevention of HIV/AIDS and STDs.
- Surveillance/Epidemiology: LHDs receive funding for HIV/AIDS surveillance and epidemiology through contracts that are based primarily on historical funding levels.

Distribution of HIV/AIDS and STD Funding to RHDs: Federal and state funding is allocated to RHDs based primarily on historical funding levels.³⁵

Regional-specific activities:

In addition to the major public health activities described above, RHDs provide the following public health services using GR and GR-Dedicated funding, which is collected from licensing and inspection fees:

- *Zoonosis Control*: Investigate and control diseases that are transmissible from animals to humans such as rabies and West Nile virus; inspect and regulate facilities where rabies suspects are quarantined; educate and train animal control officers; and consult stakeholders, including medical personnel, on zoonotic disease issues;
- *Environmental Health Services*: Ensure mold, lead and asbestos inspectors are properly trained, certified and licensed; review and approve mold training programs; and conduct environmental health enforcement activities;
- *Registries*: Maintain statewide reporting systems including the cancer registry and birth defects registry, including data monitoring and incidence and mortality data analysis;
- *Vision, Spinal and Hearing Screening Programs*: Ensure that children are screened for vision and hearing problems; ensure school screenings for students at risk of abnormal spine curvature; and educate school nurses about vision, hearing, and spinal screening services;
- *Food and Drug Safety*: License and inspect food manufacturers, wholesalers, re-packagers and distributors; collect samples for food products to be tested in state labs; Evaluate the safety of disaster-exposed foods; and ensure that products are produced from healthy animals and are slaughtered and prepared in humane, sanitary conditions;
- *Radiation Control Services*: Prevent unnecessary radiation exposure to the public through effective licensing, registration, inspection, enforcement, and emergency response; and
- *Consumer Safety*: Identify violations of regulations for bedding, abuse-able chemicals, sale of ephedrine and pseudo-ephedrine, tattooing, body piercing, and tanning facilities.³⁶

Distribution of Funding for Regional-specific Services: With the exception of Zoonosis control, funding for these services is based on historical funding levels that were established using factors such as operating costs, salaries and travel costs. Zoonosis control funding is allocated to RHDs based on the region's population and the geographic area covered.³⁷

Part Two: Addressing Issues with Current Delivery and Funding Structure

As demonstrated in Part One of this report, the system of allocating funding for public health services to both LHDs and RHDs is extremely complex. In examining the current funding and delivery system, several issues emerge that should be addressed collaboratively by DSHS and the Public Health Funding and Policy Council (PHFPC, discussed below) in order to improve the system:

- Current methods used to allocate funding to LHDs are inadequate to reflect local needs;
- Current methods of allocating funding to RHDs are inadequate to reflect changes in regional needs and population changes;
- Contracts between DSHS and LHDs are unnecessarily complicated and present significant administrative burdens to both the agency and the LHDs;
- The roles and responsibilities of LHDs and RHDs should be clearly defined to avoid duplication of efforts;
- Funding should be concentrated on providing direct services and population-based health, while funding for administrative purposes should be minimized;
- Public health funding and policy decisions should more accurately and consistently reflect local input; and
- The state should transition from contracts between LHDs and DSHS to a collaborative relationship based on cooperative agreements.

During the 82nd legislative session, Senate Bill 969 (Nelson) established the Public Health Funding and Policy Council (PHFPC) made up of RHD and LHD directors as well as experts from the state's schools of public health. The Council was created to allow for more local input into the allocation of public health funding and the setting of public health policy, and offers an opportunity to improve the public health funding and delivery system in Texas.³⁸ Since its inception, the Council has been working to address many of the issues identified above.

Allocation of Funding to LHDs

The current method of allocating funding to LHDs for public health services is extremely complex. Funding for each specific area of public health is allocated based on different criteria, and within each area of public health, federal and state funding are often allocated using different criteria.

Additionally, many of the funding formulas by which federal and state funding is allocated to LHDs fail to take into account all of the relevant factors that impact each community's specific needs. Each funding stream should be evaluated to ensure that local needs are reflected and that formulas are flexible enough to accurately reflect changes in local conditions.

DSHS, in collaboration with the PHFPC, should consider new funding formulas to allocate funding to LHDs that take into consideration:

- The population of the area being served by each LHD;
- Disease-specific morbidity in the area being served by each LHD;
- LHD efforts to prevent diseases and public health outbreaks;
- Each LHD's ability to draw down federal funds independently of DSHS; and
- Whether a LHD is in a high-poverty or border area of the state, which may necessitate more funding than the population or even disease morbidity of the area might suggest.

Special consideration should also be given to specific areas of public health policy:

Tuberculosis (TB): Although the current 8-component funding formula for TB considers the number of active TB cases in each service area, the formula does not include a component to

capture the level of Latent TB infection cases. Individuals with Latent TB have no symptoms and cannot infect others, but do have TB bacteria present in their systems and will become sick with TB if the TB bacteria in their bodies becomes active. LHDs do not receive funding to address Latent TB, but many LHDs spend significant time and resources identifying individuals with Latent TB and offering treatment to ensure that they do not develop active TB. There is currently no mechanism in place for the state to accurately capture the number of Latent TB cases by county, which makes it difficult for the TB funding formula to incorporate LHD efforts to control Latent TB. DSHS recently launched a project to improve their data collection process surrounding Latent TB and other unreported infectious disease data.³⁹ DSHS and the PHFPC should consider this new data in revising the TB funding formula.

DSHS has already begun work to revise the TB funding formula for LHDs. The agency is undertaking a comprehensive assessment and strategic planning initiative to address TB prevention and control across the state, and part of this initiative includes a new funding formula workgroup formed to recommend changes for FY 2014 and beyond. Two members of the PHFPC, as well as Texas Association of Local Health Officials (TALHO) staff, LHD directors, RHD directors, and regional TB program staff serve on this workgroup.⁴⁰

Preparedness: Although all LHDs receive a minimum allocation for preparedness activities, the majority of this funding is allocated based on population (per capita) levels, which is not always an accurate gauge of need. This is evidenced by the fact that most large cities in Texas are routinely unable to spend their entire PHEP allocation and must return part of their funding to the state, while many mid-sized LHDs must rely on funding from non-federal sources to supplement their PHEP allocation from DSHS.⁴¹ A more suitable funding formula would take into account each locality's risk for various public health emergencies. DSHS is currently conducting a comprehensive risk assessment of all local jurisdictions in the state to determine a 'risk quotient' based on the community's risk of public health threats such as terrorist attacks, natural disasters, and infectious disease outbreaks. Future funding formulas should take these risk quotients into consideration.

Funding Allocations to RHDs

As previously mentioned, the majority of public health funding received by RHDs is based on historical funding levels. This may not accurately reflect public health needs in each region and presents several potential problems:

- Historical funding does not accurately capture changes in population that may impact the level of resources a RHD must utilize to respond to public health threats;
- Historical funding does not capture changes in the number of people who are covered by a RHD as opposed to a LHD, or vice versa; and
- Historical funding does not take into consideration the disease incidence rates in an area covered by a RHD or changes to those disease incidence rates, which impacts the level of resources a RHD needs.

Despite these concerns, historical funding may be appropriate in some situations. For example, a historical funding allocation for immunizations may be sufficient for RHDs as they do not provide actual immunizations.

DSHS and the PHFPC should evaluate current methods of allocating funding to RHDs for each of the major public health areas as well as the region-specific activities to ensure that there is sufficient consideration of regional health needs, and to ensure that funding allocation methods are flexible enough to reflect changes in population and regional needs.

Contracting Issues

The complicated nature of the contracting process between DSHS and LHDs has created unnecessary administrative burdens for both entities. The volume of contracts and the actual contracting process should be reevaluated to search for additional efficiencies.

Reducing the Number of Contracts: Until recently, LHDs had numerous DSHS contracts within each of the major public health funding areas. Each of these contracts came with separate contract managers, contract auditors, and compliance and reporting requirements, meaning that LHDs are visited multiple times in a single year by auditors and contracts managers in order to comply with grant contract requirements. This places a huge administrative burden on both the LHDs and on DSHS.

Based on a provision of Senate Bill 969, DSHS has worked over the current interim with the PHFPC and TALHO to propose and execute a bundled contracting system to simplify the current process.⁴² DSHS estimates that beginning in FY 2013, about 281 LHD contracts will be bundled into 50-60 'core contracts', each of which will have one grant manager and one auditor.⁴³ Each of these core contracts will have multiple sub-contracts with separate budgets and requirements in order to ensure that federal and state funding and contracting requirements are met. This arrangement will reduce travel time and expenses among DSHS contract management staff, and will also reduce the staff time and resources at the local level that must be focused on accommodating these contract inspections and ensuring that other contract requirements are met.

Flexibility Within Contracts: In addition to reducing the volume of contracts between LHDs and DSHS, the agency and the PHFPC have worked to increase the flexibility LHDs have to transfer funds between spending categories within their contracts. While the federal government allows DSHS to transfer 25% of funds between spending categories, LHDs have long been held to a 10% transfer authority threshold. Recently, DSHS has amended this to align LHD transfer authority flexibility with the 25% threshold allowed in federal contracts.⁴⁴

Additionally, LHDs have typically been required to obtain formal prior approval from DSHS to purchase equipment that costs more than \$500, while DSHS must only obtain such approval from federal grants managers for equipment purchases of more than \$5,000. DSHS has worked with the PHFPC to develop an equipment purchasing policy that reflects the \$5,000 threshold included in federal grant requirements.⁴⁵

DSHS and the PHFPC should continue to work to expand flexibility within contracts for LHDs. One area that deserves further examination is the ease with which LHDs are able to utilize staff between contracts, especially during emergencies. For example, during a food-borne illness outbreak, LHD staff who are funded through a TB grant cannot be deployed to address the food-borne illness outbreak. DSHS should re-evaluate such contract requirements to allow LHDs

more flexibility in the use of personnel and other resources during disaster response activities, outbreaks, and other appropriate public health threats. Since some of these staffing restrictions may be due to federal requirements, any contract requirement changes should ensure that LHDs comply with federal and state law and funding requirements.

Defining the Roles of LHDs, RHDs, and the DSHS Central Office

There is inevitably some overlap in the functions of RHDs and LHDs due to their collaborative nature. RHDs step in where LHDs are unable to perform essential public health services, and RHDs often rely on LHDs to provide essential activities such as prevention and administration of immunizations. Similarly, some overlap between RHDs and the DSHS Central Office exists because the RHDs act as agents of the Central Office and often assist in performing compliance activities related to DSHS grants with LHDs. Although there are legitimate reasons for some overlap between RHDs, LHDs, and the DSHS Central Office, clearly defining the roles of these entities within the public health delivery system will help to avoid duplicative efforts.

Local Health Department Role:

One of the duties of the PHFPC, as outlined in SB 969, is to define the core public health services a LHD should provide.⁴⁶ Although these services are currently outlined in Health and Safety Code Chapter 121, this list was established in 1989 and should be reviewed. In determining what essential public health functions LHDs should offer, one tool that could be useful is the national effort to accredit local public health departments.

Public Health Accreditation: The national Public Health Accreditation Board (PHAB) was formed in 2007 to implement and oversee national public health department accreditation in an effort to create consistent standards of service across LHDs. The national accreditation process was established in 2011, requiring LHDs to meet certain service delivery standards, receive a comprehensive assessment via a site visit by the PHAB, and make commitments to continuous quality improvement.⁴⁷

At the state level, TALHO created the Public Health Accreditation Council of Texas (PHACT) in 2008 to help LHDs understand the accreditation process and prepare for the possibility that accreditation could become mandatory in order to receive federal funding in the future. PHACT holds regular conference calls for LHDs on accreditation, meets monthly to gauge LHD accreditation interest and activity, and holds annual conferences on the accreditation process. Although no LHDs in Texas have completed the full one-year accreditation process thus far, many have expressed interest and begun the initial steps towards achieving accreditation.⁴⁸

Regional Health Department Role:

The role of RHDs should also be evaluated and clearly defined. The current role of RHDs can be divided into four general functions:

1. Acting as the LHD in areas of the state where one does not exist;
2. Filling gaps when LHDs are unable or unwilling to provide essential public health services;
3. Mobilizing state resources in public health emergencies and disasters; and

4. Providing services that no other health entity provides such as zoonosis control, environmental health services, maintenance of statewide health registries, school health screening programs, food and drug safety, radiation control services, and consumer safety activities.⁴⁹

DSHS Central Office

The DSHS Central Office serves as the state-level administrator of public health services. In this capacity, they serve as the liaison between federal and local public health officials, award and manage contracts with LHDs, set statewide public health policy priorities, provide quality assurance services, and monitor and enforce state and federal requirements for the provision of various public health services.

The Central Office also serves specific public health roles within each of the major public health functions described throughout this report. For example, they provide epidemiological surveillance services in the three state-run public health labs, provide statewide preparedness planning and training, and operate the disaster response and recovery unit, among other functions.

Minimizing Administrative Costs

There is currently no system of tracking or reporting how much funding RHDs or LHDs expend on administrative functions. In order to ensure that every dollar directed to public health is used efficiently and effectively, DSHS, in coordination with the PHFPC, should consider the feasibility and benefits of a cap on the percentage of state and federal public health funds that can be used on administrative expenses at LHDs, RHDs, and the DSHS Central Office. Any recommendations stemming from the consideration of such a cap would have to ensure that all of these entities are able to comply with state and federal statutory and contracting requirements.

In recent months, DSHS has explored the possibility of contracting with LHDs, non-profit entities, and private entities to perform administrative functions that are currently performed by the DSHS Central Office and RHDs. For example, the agency is in the process of transferring the activities of the four remaining RHD-operated Women, Infants and Children (WIC) clinics to LHDs and non-profit organizations. DSHS should continue to explore these possibilities and should, in collaboration with the PHFPC, evaluate public health administrative functions currently provided by the DSHS Central Office, RHDs, and LHDs that may be more efficiently or effectively performed by another entity.⁵⁰

Cooperative Agreements

One of the requirements of Senate Bill 969 is for DSHS to establish a continuous collaborative relationship with LHDs.⁵¹ Although this will be an ongoing effort and success in this area will be difficult to measure, the agency has made significant progress by working with the PHFPC to reduce administrative burdens on LHDs and simplify and streamline contracts, as described above. The agency must also work to transition from contractual agreements to cooperative agreements with LHDs, similar to the relationship between DSHS and the CDC. To do so, the

agency will transition to the use of the term 'cooperative agreements' to describe their relationship with LHDs beginning in 2014.⁵²

Section III: Conclusion

The public health funding and delivery system in Texas is a complex partnership between LHDs, RHDs, and DSHS. Each of these entities plays an essential role in protecting the health of Texans, and it is essential that all three entities work together in a collaborative nature to ensure that local and statewide public health needs are met in the most effective and efficient manner possible. Steps can be taken to improve the current public health system, such as re-evaluating the methods of allocating federal and state funding from DSHS to LHDs and RHDs, considering a cap on the percentage of funding that can be used on administrative functions, determining if any functions currently provided by public health entities can be more effectively provided by other entities, and allowing maximum flexibility within LHDs contracts while still ensuring compliance with federal funding requirements.

Section IV. Recommendations

- 1. Direct DSHS, in collaboration with the PHFPC, to develop new funding formulas for federal and state funds that flow to LHDs. New formulas should be based on the population of the counties served by each LHD, disease morbidity rates, the level of existing LHD disease prevention efforts, each LHD's ability to draw down federal funds independently from DSHS, and whether a LHD serves border and high-poverty areas of the state, which could necessitate more funding than their population or disease rates may suggest.**
- 2. Require DSHS, in coordination with the PHFPC, to consider the feasibility and benefits of a cap on the percentage of public health funds that can be used on administrative costs at RHDs and LHDs.**
- 3. Direct DSHS, in coordination with the PHFPC, to evaluate public health functions currently provided by DSHS, RHDs, and LHDs, and determine if those services can be more effectively provided by another entity including the private sector.**
- 4. Direct DSHS to create a policy to allow LHDs more flexibility in the use of personnel and other resources during disaster response activities, outbreaks, and other appropriate public health threats. The policy should specify that allowances for use of funds must comply with federal and state law and funding requirements.**

¹ Texas Health and Safety Code, Chapter 121, Section 121.002.

² Dr. David Lakey, Texas Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, March 20, 2012, p8.

³ Department of State Health Services, *Health Service Regions Public Health Functions*, July 6, 2012.

⁴ Information provided by Department of State Health Services via email, June 14, 2012.

⁵ Does not include direct LHD funding from federal government.

⁶ Information provided by Department of State Health Services via email, November 19, 2012.

⁷ *Id.*

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- ⁸ Information provided by Public Health Funding and Policy Council Chair via email, November 9, 2012. Based on survey of Local Health Departments with responses from 85% of participating Local Health Departments.
- ⁹ Department of State Health Services, *Local Health Department Contracts with Strategy Totals*, June 26, 2012.
- ¹⁰ Information based on telephone conversation with Department of State Health Services via email, June 28, 2012.
- ¹¹ *Supra* note 4.
- ¹² Information obtained from: <http://www.cdc.gov/vaccines/programs/vfc/parents/default.htm>. Accessed July 2, 2012.
- ¹³ *Supra* note 4.
- ¹⁴ Information provided by Department of State Health Services via email, July 10, 2012.
- ¹⁵ *Supra* note 4; *Supra* note 13.
- ¹⁶ Information provided by Department of State Health Services via email, October 11, 2012.
- ¹⁷ *Supra* note 4; *Supra* note 13.
- ¹⁸ *Supra* note 4.
- ¹⁹ Information provided by Department of State Health Services via email, June 19, 2012.
- ²⁰ Information provided by Department of State Health Services via email, June 10, 2012.
- ²¹ Department of State Health Services, *Health Service Regions Public Health Functions*, July 6, 2012.
- ²² *Supra* note 4.
- ²³ *Supra* note 19.
- ²⁴ *Id.*
- ²⁵ *Id.*
- ²⁶ *Id.*
- ²⁷ *Id.*
- ²⁸ Department of State Health Services, *Tuberculosis Funding Overview*, June 19, 2012.
- ²⁹ Information provided by Department of State Health Services via email, July 13, 2012.
- ³⁰ Department of State Health Services, *DSHS by Strategy and Sub-Strategy with Services Provided or Paid For*, July 6, 2012.
- ³¹ Information Department of State Health Services via email, July 11, 2012.
- ³² *Id.*
- ³³ Information based on telephone conversation with Department of State Health Services, July 10, 2012.
- ³⁴ *Supra* note 29.
- ³⁵ *Supra* note 32.
- ³⁶ *Supra* note 20.
- ³⁷ *Supra* note 30.
- ³⁸ Senate Bill 969, Nelson, 82nd Regular Legislature.
- ³⁹ "Tuberculosis Funding Overview", provided by DSHS staff, June 19, 2012.
- ⁴⁰ *Id.*
- ⁴¹ *Id.* at June 14, 2012
- ⁴² Senate Bill 969, Nelson, 82nd Regular Legislature.
- ⁴³ Dr. Adolfo Valadez, DSHS, Presentation to the Public Health Funding and Policy Council, "PHEP & TB Funding Updates & Contract Bundling Overview", April 19, 2012.
- ⁴⁴ Department of State Health Services, *DSHS Plan for Transition to Cooperative Agreements*, November 2012.
- ⁴⁵ *Id.*
- ⁴⁶ Senate Bill 969, Nelson, 82nd Regular Legislature.
- ⁴⁷ "Guide to National Public Health Department Accreditation", Public Health Accreditation Board, May 2011.
- ⁴⁸ Information based on email from Texas Association of Local Health Official staff, June 20, 2012.
- ⁴⁹ "Health Service Regions Public Health Functions", provided by DSHS, July 6, 2012.
- ⁵⁰ *Id.* at June 14, 2012.
- ⁵¹ *Supra* note 38.
- ⁵² *Supra* note 44.

Charge # 8-Mental Health: *Review the state's public mental health system and make recommendations to improve access, service utilization, patient outcomes and system efficiencies. Study current service delivery models for outpatient and inpatient care, the funding levels, financing methodologies, services provided and available community-based alternatives to hospitalization. The review should look to other states for best practices or models that may be successful in Texas. The study shall also review and recommend "best value" practices that the state's public mental health system may implement that will most efficiently maximize the use of federal, state and local funds.*

Section I: Background

Public mental health services are essential to the individuals who receive them as well as to their families and communities. The adequate provision of these services also ensures that individuals with mental illness are not served in more costly and less clinically appropriate settings such as county jails and hospital emergency rooms. In Texas, the Department of State Health Services (DSHS) oversees the administration of a system of inpatient and outpatient public mental health services. This system consists of a network of state hospitals, community mental health services, and crisis stabilization services.

State Hospitals:

- Ten state-owned and operated inpatient facilities for children and adults.

Community Services:

- 39 Local Mental Health Authorities (LMHAs) that provide community-based mental health services and crisis stabilization services for children and adults in 247 of the state's 254 counties; and
- The NorthSTAR waiver, which provides community-based mental health services for adults and children through a managed care model in a seven-county area in North Central Texas.

Crisis Stabilization Services:

- Services such as short-term respite, mobile outreach teams, extended observation units, and crisis hotline services, which are provided through the state's LMHAs.

Providing these services is very costly for the state, with total state funding in 2009 reaching \$763 million.¹ Despite the severe financial constraints facing our state during the last legislative session, the Legislature increased overall funding for mental health by \$52.2 million and increased General Revenue funding for mental health by \$46.6 million in order to maintain 2010-11 levels of capacity.² Despite this increase in funding, there are still significant mental health needs in our state that must be addressed involving capacity and access to services, service delivery, outcomes, and costly infrastructure within our state hospital system.

This report is intended to give a high-level overview of the public mental health system in Texas and to make recommendations for potential improvements to this system. An extensive examination of the state's public behavioral health system was recently conducted by the Public Consulting Group (PCG) as the result of Rider 71 which was included in House Bill 1 during the 82nd Legislative session.³

Section II: Analysis

The public mental health system in Texas is very complex and costly, with funding for the major elements of the system stemming from a variety of federal, state and local sources. The three primary elements of this system are inpatient services in state hospitals, community-based services, and crisis services.

State Hospitals

Inpatient services for individuals with mental illness who present a danger to themselves or others are provided through nine state-owned and operated mental hospitals and one state-owned and operated residential treatment facility for youth. The purpose of these entities is to stabilize patients in order for them to be treated in a less restrictive treatment setting in the community and to restore competency for those who have entered a state hospital through the criminal justice system. Almost 90% of funding for state hospitals comes from state General Revenue, while the remainder is federal funding.⁴ Collectively, these ten facilities have the capacity to house 2,501 individuals. The division of beds among these facilities and the populations they serve are depicted in Figure 1.

Figure 1. Number of Beds at State Mental Health Hospitals in Texas, September 2012⁵

Facility	Population Served	Beds
Austin State Hospital	Adults and Children	299
Big Spring State Hospital	Adults Only	200
El Paso Psychiatric Center	Adults and Children	74
Kerrville State Hospital	Adults Only	202
North Texas State Hospital- Vernon Campus	Adults and Children	351
North Texas State Hospital- Wichita Falls Campus	Adults and Children	289
Rio Grande State Center	Adults and Children	55
Rusk State Hospital	Adults Only	335
San Antonio State Hospital	Adults and Children	302
Terrell State Hospital	Adults and Children	316
Waco Center for Youth- Residential Treatment Facility	Children Only	78
	<i>TOTAL</i>	<i>2,501</i>

Forensic versus Civil Commitments

DSHS has the authority to determine how state hospital capacity is divided between forensically and civilly committed patients. Currently, 936 (38.5%) of the 2,501 state hospital beds are dedicated to forensic patients, while the remaining are used for civil commitments.⁶ Individuals who have been committed forensically have been charged with a crime and have either been found Not Guilty by Reason of Insanity (NGRI), or have been found incompetent to stand trial due to their mental illness. Civil commitments are those in which a person enters the state hospital through an avenue other than the criminal justice system. This may occur involuntarily through an order for mental health services by a Magistrate or Peace Officer, or voluntarily through a referral by a community mental health provider. The differences between civil and forensic commitments are outlined in Figure 2.

Figure 2. Civil vs Forensic Commitments⁷

	Commitment Criteria	Parties Involved	Types of Commitments	Criteria for Exiting the State Hospital
<u>Civil</u>	Individual presents symptoms of mental illness that represent a danger to themselves or others	<ul style="list-style-type: none"> • Magistrates/Peace Officers • Adult Relatives or Guardian • Admissions Team • Treatment Team 	<ul style="list-style-type: none"> • Emergency Detention (24 Hour) • Orders of Protective Custody (30 Day Maximum) • Court-Ordered Mental Health Services (90 days to 12 months) 	<ul style="list-style-type: none"> • Treatment team determines individual is no longer a threat to themselves or others and can be safely treated in a less restrictive setting; • An appropriate community placement exists
<u>Forensic</u>	Individual with mental illness or instability has been charged with a crime and deemed not competent to stand trial or found Not Guilty by Reason of Insanity (NGRI)	<ul style="list-style-type: none"> • Court/Judges/Juries • Admissions Team • Treatment Team 	<ul style="list-style-type: none"> • Awaiting Adjudication (Competency Restoration) • Post-Adjudication (NGRI) 	<ul style="list-style-type: none"> • Treatment Team recommends that an individual is competent to stand trial or (for NGRI) is no longer an imminent threat and can be safely treated in a less restrictive setting; • Judge/court has approved discharge or changes in status

Issues Facing State Hospitals

The ten state-owned inpatient mental health facilities across the state provide effective treatment to individuals with mental illness in a secure environment. However, these facilities have

increasingly dealt with issues related to their capacity to handle a large volume of forensic commitments and the aging infrastructure of state hospital buildings.

Forensic Capacity

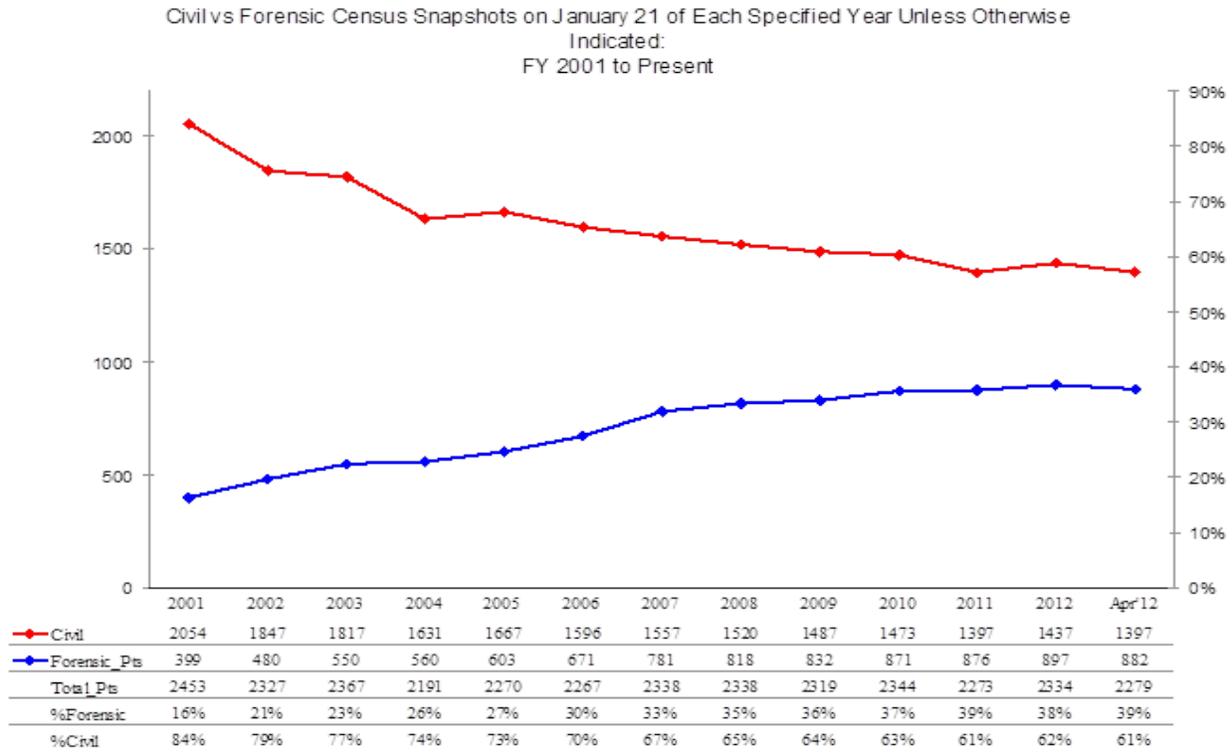
Forensic commitments to our state hospitals have risen sharply in the past decade, as shown in Figure 3. The increase in forensic commitments has created capacity issues at state hospitals and has reduced their ability to accommodate civilly committed patients. In recent years, the volume of forensic commitments has overwhelmed the state hospital system and has exceeded capacity. This has resulted in long wait times between forensic patients being ordered to receive inpatient competency restoration and actually being admitted to a state hospital. Often, this time is spent in a county jail. As recent as October 2011, the average wait time between commitment and admission was 72 days for forensic commitments and 91 days for maximum security forensic commitments.⁸

Forensic Capacity Lawsuit: In response to this wait time, a lawsuit (*Taylor v Lakey*) was filed against the state of Texas in February 2007 claiming that the wait time between the judicial determination that an individual is incompetent to stand trial and their admission to a state hospital was excessive and violated the individuals' right to due process.⁹ The District Court ruling in this case, issued to DSHS in February 2012, would require that a detainee found to be incompetent must be admitted to a facility to receive inpatient competency restoration services within 21 days of the commitment order.¹⁰ The state is currently appealing the ruling of the District Court. Irrespective of that appeal, DSHS has:

- Purchased 90 beds at inpatient facilities in the community (discussed further in next section);
- Added 100 additional maximum security forensic beds at North Texas State Hospital-Vernon and Rusk State Hospital; and
- Added 54 transitional forensic beds at North Texas State Hospital-Wichita Falls and Austin State Hospital for individuals who are transitioning from a maximum security to a non-maximum security forensic bed once they have been found to no longer present a manifest danger.

The biennial cost of making these changes to forensic capacity is \$36.3 million. These efforts reduced the forensic commitment waiting list from 292 in October 2011 to 121 as of November, 14, 2012.¹¹ It is anticipated that, with these additional resources, a 21-day admission to inpatient competency restoration will be achieved by the end of 2012.¹²

Figure 3. Civil and Forensic Beds in State Hospital System, FY 2001 to April 2012¹³



Aging Infrastructure

Texas' state hospitals have an aging infrastructure that is costly to maintain. The majority of state hospitals were built prior to 1965, and some are over 100 years old. Although the older state hospital buildings generally remain structurally sound, they require ongoing, costly maintenance and repairs to maintain safety and hospital accreditation standards.¹⁴ On some campuses, many of the buildings are not actually in use due to conditions that make them unsafe for habitation. For example, 12.7% of the buildings on the Terrell State Hospital campus and 11.1% of the buildings on the Big Spring Hospital campus are not currently in use, and would not be suitable for habitation even with significant repairs.¹⁵ Over the past several sessions, the state has issued bonds to fund the repair and renovation of aging state hospital buildings.

Figure 4. Bond Expenditures for State Hospital Infrastructure Repairs and Renovation, 2006 through 2012¹⁶

<i>Year</i>	2006	2007	2008	2009	2010	2011	2012*
<i>Bonds Expended (in millions)</i>	\$5.9	\$11.7	\$8.2	\$23.4	\$36.7	\$18.4	\$11.1

*2012 expenditures as of October 1, 2012.

Potential Solutions to Issues Facing State Hospitals

In order to address the issues at state hospitals related to forensic capacity and aging infrastructure, the state has utilized alternative inpatient settings such as step-down units on state hospital campuses and has purchased beds in hospitals in the community outside of the state hospital system. The state has also sought to divert patients from state hospitals altogether through programs such as the Outpatient Competency Restoration Program and the Youth Empowerment Services (YES) waiver. The expansion of these approaches should be considered in order to relieve pressure on the aging infrastructure and limited capacity of our state hospitals.

Alternative Inpatient Settings

Step Down Units: In March 2011, the state converted 120 beds at Rusk, Big Springs and Austin State Hospitals to psychiatric residential rehabilitation beds. These beds offer a 'stepped down' level of services for patients who require extended residential inpatient treatment but are no longer a threat to themselves or others and can therefore be served at a lower level of care than traditional state hospital beds. The use of these 'step down' units has saved the state \$3 million per year in General Revenue due to reduced staffing needs, and has freed up space for traditional beds in the state hospital system. Since the establishment of these step down units, 228 patients have been served in these facilities and 63 patients have been restored to competency and discharged.¹⁷ Although some stakeholders have suggested expanding the use of these facilities, the average daily census for the 120 existing step down beds is 110, suggesting that there is not currently a need to expand this model.¹⁸

Purchasing Bed Capacity in Community Settings: In order to expand inpatient capacity and comply with the ruling in the *Taylor v Lakey* lawsuit, DSHS has contracted with LMHAs, county-owned facilities, and private psychiatric hospitals throughout the state to purchase a total of 462 beds, 120 of which have been forensic and 342 of which have been civil beds.¹⁹

Purchasing beds in the community has several advantages:

- Expands capacity to provide inpatient mental health services;
- Generates cost savings to the state: beds purchased in the community cost an average of \$433 per day while the average cost of a state hospital bed is \$544 per day;
- Allows more local options for civilly committed individuals to be served in their home communities; and
- Relieves the burdens of maintaining costly infrastructure, operating facilities, and staffing that exist at state hospitals.

As the state continues to deal with capacity issues and an aging hospital infrastructure that is costly to maintain, DSHS should continue to pursue opportunities to purchase bed space in the community.

Jail-Based Competency Restoration: In addition to contracting with entities such as counties, private hospitals, and LMHAs, the state should examine the potential of additional options such as jail-based competency restoration. Under this model, which has been utilized in Arizona, Louisiana, and California, individuals alleged to have committed felonies who have been deemed mentally incompetent to stand trial receive competency restoration services and court-ordered treatments in a county jail. Rather than waiting in a county jail with limited or no mental health

services while a space becomes available in a state hospital, jail-based competency restoration allows treatment to begin immediately upon entrance into a county jail. The state contracts with a private entity that provides intensive psychiatric treatment, acute stabilization services, and court mandated treatment using trained clinical staff. The private entity sub-contracts with a county jail to provide security and management of patients as well as food and medications. According to a cost analysis performed by DSHS, a Texas jail-based competency restoration program would cost approximately \$299 per person per day, compared to \$507 to \$544 per person per day the state currently pays to restore competency in state hospitals and \$497 to \$614 per person per day the state currently pays to restore competency in community-based facilities.²⁰ In addition to state savings, counties would likely see reduced costs because they would no longer be paying to hold individuals found incompetent to stand trial in their county jails while they awaited a space at a state hospital or other inpatient setting.

Despite these cost savings, there are other factors that must be considered when determining whether to pursue jail-based competency restoration. First, the competency restoration rates in jail-based programs may not be as high as in state hospitals and community settings.²¹ Second, if Texas were to contract with a private entity to provide jail-based competency restoration services, it would need to make sure that the proper safeguards were in place to ensure that appropriate treatment is provided using qualified staff. Finally, there are other legal considerations that must be taken into account, such as how to ensure equal protections for individuals receiving competency restoration in a jail-based setting versus a state hospital or other inpatient psychiatric setting. The state should consider pursuing a pilot of this model among a small population of forensically committed individuals that are ordered to receive competency restoration services in an inpatient setting in order to assess the potential state-wide cost savings and success of restoring competency in a jail-based program.

Diversions From State Hospitals

In addition to utilizing alternative inpatient hospital settings to address capacity and infrastructure issues, the state has pursued tactics to divert individuals from state hospitals who can effectively and safely receive mental health services in less restrictive settings.

Outpatient Competency Restoration Programs: Outpatient Competency Restoration (OCR) programs allow individuals found incompetent to stand trial but not deemed a danger to self or others to receive competency restoration services in a community setting, rather than an inpatient setting. Since 2008, DSHS has established eleven pilot programs through ten LMHAs and one NorthSTAR services provider to provide OCR services. Collectively, 784 individuals who were deemed mentally incompetent to stand trial for misdemeanors or felonies that did not involve serious bodily injury have been diverted from state hospitals to one of the state's eleven OCR pilot programs. These pilots have resulted in significant cost avoidance for the state--the establishment and operation of these pilot programs has cost \$11.6 million as compared to the \$33.7 million that would have been required to restore these 784 individuals to competency in state hospitals.²²

Some stakeholders have called for the expansion of Outpatient Competency Restoration programs. However, there is currently no waiting list for these services and all major geographical areas of the state are currently served by existing Outpatient Competency

Restoration pilot programs. Expansion to smaller geographical areas would not be cost effective because the low levels of need would not justify the significant expenditure needed to establish a new pilot site.²³ However, these programs have been highly effective in treating patients in the least restrictive environment and accruing cost savings for the state. Therefore, services should be continued at the existing eleven pilot sites and DSHS should continue to monitor the need for expansion of these programs.

Youth Empowerment Services (YES) Waiver: The 1915(c) Medicaid Youth Empowerment Services (YES) waiver provides intensive outpatient psychiatric and support services not typically provided under Medicaid or the Children's Health Insurance Program (CHIP) to 3-18 year olds with Severe Emotional Disturbance (SED). Often, the lack of these services in the community results in these children being treated in inpatient settings and in some cases, the parents of these children relinquish custody to allow them to qualify for Medicaid mental health services. The YES Waiver seeks to reduce inpatient hospitalizations and parental relinquishment of these children.²⁴

The YES waiver is currently being piloted through the LMHAs in Bexar, Travis, and Tarrant Counties and is expected to be expanded to Harris County in April 2013, with enrollment at each waiver site capped at 100 individuals. Of the 300 current waiver slots, 67 have been filled as of October 2012, while an additional 75 children are either awaiting treatment plans, are scheduled for eligibility determination, or are waiting to be assessed for eligibility.²⁵

Although there were nearly 400 children on interests lists for the YES waiver as of May 2012, LMHAs have been unable to fill available slots due to low levels of provider enrollment.²⁶ Providers were initially slow to enroll in the program due to concerns about reimbursement rates and program requirements. However, these issues are actively being addressed by the Health and Human Services Commission (HHSC) and DSHS through an increase in reimbursement rates to make them comparable to other waiver programs, clarifications of the rules for provider enrollment, and expanded outreach to recruit additional providers.

Therefore, once these provider enrollment issues are resolved by the agencies, all of the available slots should be filled and demand for the waiver will likely exceed available slots. Due to the high demand for waiver slots, the potential of costs savings achieved by providing these waiver services, and the positive outcomes that have been achieved so far for children served through the waiver, the state should seek to expand the waiver to additional sites throughout the state.

1915(i) State Plan Amendment:

As previously discussed, the state hospital system is nearing or already over capacity. While Texas' state hospitals are intended to provide short-term stabilization services, many current patients have resided in state psychiatric facilities for a year or more or have had multiple stays in these facilities. Many of these individuals have a history of chronic homelessness, have inadequate family support in the community, and require assistance with activities of daily living. This population is extremely costly to care for, exacerbates capacity issues in our state hospitals, and experiences great difficulty reaching positive clinical outcomes.²⁷

Until recently, the majority of community support services that are needed to allow this population to remain in the community and avoid lengthy or frequent stays in state hospitals

were not eligible to be provided through Medicaid. Therefore, these services, such as evidence-based rehabilitation, psychosocial rehabilitation, transitional assistance for those moving from an inpatient setting to the community, and specialized behavior therapy, are currently financed through General Revenue or local funds, or are simply not available to individuals.

However, states were recently given authority under federal law to seek 1915(i) State Plan Amendments (SPAs) allowing them to provide Medicaid Home and Community-Based Services, such as those listed above, to adults with severe mental illness. States may target specifically defined populations and provide them with services which are different in amount, duration, and scope than those provided to other Medicaid recipients.²⁸ In their Legislative Appropriations Request (LAR), DSHS has requested funding to provide the state matching funds needed to pursue a 1915(i) SPA to serve individuals who have had frequent or extended stays in a state hospital due to a lack of supportive outpatient services.²⁹

The state should consider seeking a 1915 (i) SPA to provide home and community based services to individuals with a history of frequent or extended stays in state hospitals and chronic homelessness. This will allow the state to pull down federal funds, alleviate capacity issues at state hospitals, and lead to better outcomes for this population.

Community-Based Mental Health Services

Community-based services include counseling, psychiatry, and other physician services, the prescribing of medications necessary to manage mental health disorders, targeted case management, and rehabilitation, among other services. In 247 of the state's 254 counties, DSHS contracts with the state's 39 Local Mental Health Authorities (LMHAs) to provide community-based services for children and adults. In a seven county area in North Texas, these services are provided through a 1915(b) waiver known as NorthSTAR. Under this waiver, community mental health services are delivered by private providers and community centers that contract with Value Options, a Behavioral Healthcare Organization (BHO). In Fiscal Year 2011, 243,259 adults and 63,313 children received community mental health services through either an LMHA or a NorthSTAR provider.³⁰

Local Mental Health Authorities (LMHAs)

LMHAs are local entities designated by the state to plan, develop policy, coordinate, and allocate community mental health services to Medicaid eligible and medically indigent individuals in a specific geographical region of the state. LMHAs are responsible for developing networks of providers to serve eligible individuals in their designated service areas, and may also serve as the provider of last resort.³¹ DSHS contracts with the state's 39 LMHAs to ensure the provision of mental health services to Medicaid-eligible and medically indigent individuals in their designated service area. In all of the state's 39 LMHA service areas outside of the NorthSTAR region, Community Mental Health Centers ('Community Centers') are designated as the LMHA.³² Community Centers are legal entities formed by local taxation authorities which receive tax revenue from these authorities to meet local community service funding match requirements.

Funding: Funding for LMHAs comes from federal, state, and local sources.

- Federal Funding: Federal funds accounted for 37% of total LMHA funding in FY 2011.³³ Funding from federal sources such as the Mental Health Block Grant, Title XX, and the Social Services Block Grant are distributed from DSHS to LMHAs retrospectively on a quarterly basis.³⁴ Outside of these sources, LMHAs directly bill Medicaid for reimbursement.³⁵
- State Funding: State General Revenue (GR) accounted for 50% of total LMHA funding in FY 2011.³⁶ State GR is used to provide the match for Medicaid and to meet Maintenance of Effort (MOE) requirements for the federal Mental Health Block Grant. Additionally, community mental health services for medically indigent individuals are funded primarily by GR, in addition to some local funds.³⁷ Current allocations of GR to LMHAs are based on historical funding levels and are distributed on a quarterly basis.
- Local Funding: Local funds across all 39 LMHAs accounted for 13% of total LMHA funding in FY 2011.³⁸ LMHAs are required to contribute a local match for state GR funds received based on the weighted per capita income in each LMHA services area.³⁹ The largest sources of local funds contributed by LMHAs stem from Pharmaceutical Assistant Programs (PAP) contributions of donated medications, county tax funds, reimbursements from patients and private insurance, and grants and gifts from foundations, corporations, and individual donors.⁴⁰

Eligibility for Community Services: In order to manage the demand for mental health services, the state has established clinical eligibility criteria that individuals must meet in order to receive community-based mental health services. This criteria, known as the mental health priority population, includes adults with a diagnosis of severe depression, bipolar disorder, or schizophrenia. For children ages 3-17, the priority population are those who have a serious functional impairment, are at risk of disrupting their living or child care environment due to psychotic symptoms, or are enrolled in a school Special Education program due to serious emotional disturbance. The priority population criteria are applied differently to Medicaid and medically indigent individuals, as described below.

Services for Medicaid Eligible Individuals: Depending on an initial assessment of their clinical needs, individuals eligible for Medicaid may receive the full array of behavioral health services offered under the standard Medicaid benefit.⁴¹ Medicaid-eligible individuals who display a clinical need for more intensive services and fall into the state's mental health priority population are also eligible to receive targeted case management and rehabilitation services. However, under Texas' Medicaid State Plan for targeted case management, LMHAs are the exclusive provider of these services, although LMHAs may sub-contract with private providers to deliver rehabilitation services.

Services for Medically Indigent Individuals: Medically indigent individuals (those who fall below 200% of the Federal Poverty Level (FPL) and are uninsured) who fall into the priority population may receive community mental health services through an LMHA.⁴² Unlike services for those served through the Medicaid entitlement program, services for the medically indigent are delivered as funding is available. LMHAs may assess sliding scale fees on medically

indigent individuals with incomes above 150% of the FPL, but the vast majority of medically indigent patients receiving mental health services through LMHAs fall well below this income level, with about 95% falling below 139% of the FPL.⁴³ For some LMHAs, this results in a waiting list for the medically indigent seeking services. As of September 2012, 8,369 adults were waiting for community mental health services. 5,942 of these individuals were not receiving any services, while the remaining 2,427 were receiving medications but were waiting to receive other services. As of September 2012, 289 children were waiting to receive community mental health services.⁴⁴ 191 of these children were not receiving any services, while the remaining 71 were receiving some services, but were waiting to receive more intensive services. Historical trends in the waiting lists for adult and children's community mental health services are depicted in Figures 5 and 6.

Figure 5. Waiting List for Community Services, Adults

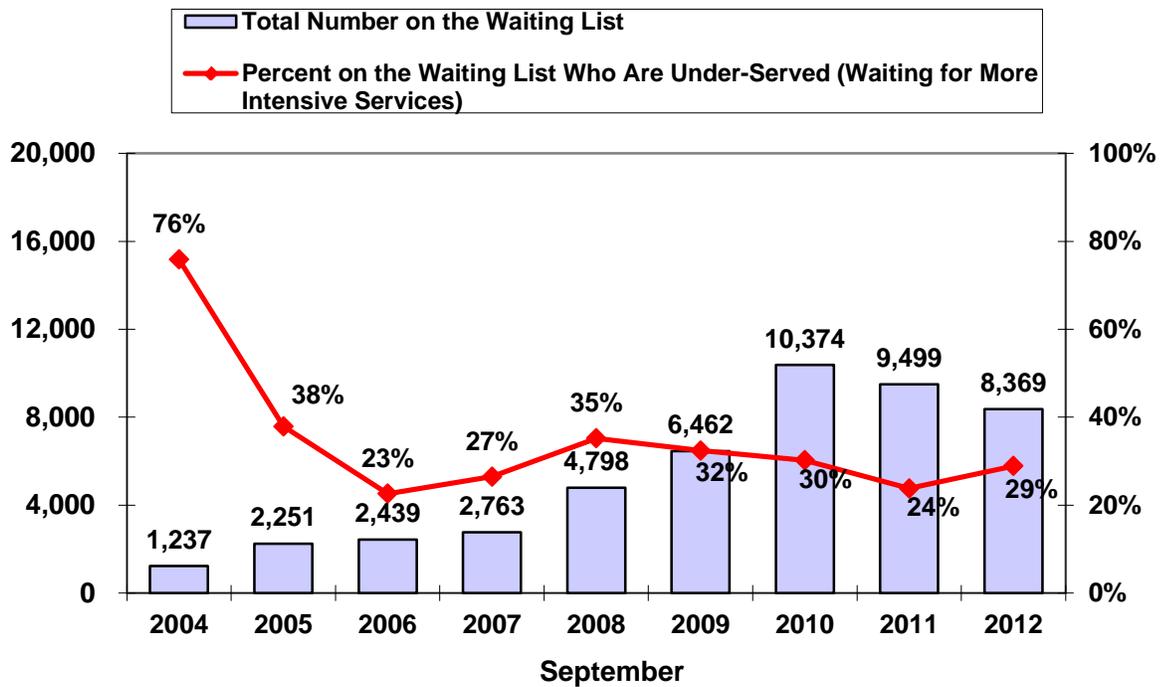
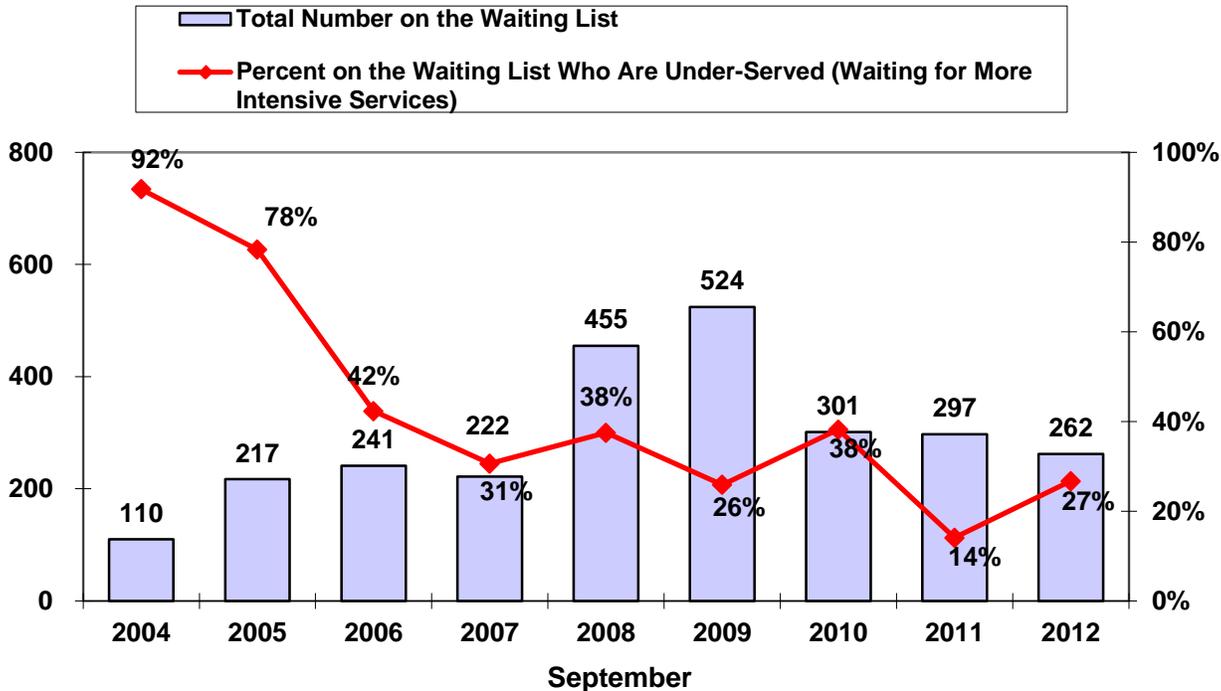


Figure 6. Waiting List for Community Services, Children



NorthSTAR

Medicaid-eligible and medically indigent individuals residing in a seven-county area in North Texas (Dallas, Collin, Hunt, Rockwall, Kaufman, Ellis, and Navarro) receive community mental health services through a 1915(b) Medicaid waiver known as NorthSTAR.⁴⁵ Under this managed care model, which was established in 1999, DSHS contracts with a Behavioral Health Organization (BHO) who assumes the risk of delivering all covered services to eligible individuals in the service area. The state currently contracts with the BHO ValueOptions to perform utilization management functions, manage a provider network, adjudicate provider claims, maintain a quality management program, and handle customer complaints and appeals department.⁴⁶ In addition to managing a large network of private providers, ValueOptions also contracts with three Community Centers (former LMHAs) in the NorthSTAR service area to provide mental health services.⁴⁷

North Texas Behavioral Health Authority: The North Texas Behavioral Health Authority (NTBHA) serves as the LMHA in the NorthSTAR area. NTBHA provides no direct services, but provides oversight and planning functions including monitoring the state contract with ValueOptions, coordinating local input into regional planning, providing ombudsmen services for consumer complaints, conducting audits of ValueOptions and providers to ensure quality of care, and monitoring quality improvement projects.⁴⁸

Funding: NorthSTAR is a blended funding model, meaning that federal, state, and local funding are combined into one program budget. In FY 2012, funding for the program was as follows:

- Federal Funding: Federal funds accounted for 67.3% of total NorthSTAR funding in FY 2012. This funding comes primarily from Medicaid, Medicare, the Mental Health Block Grant, and the Social Services Block Grant.
- State Funding: State GR accounted for 30% of total NorthSTAR funding in FY 2012. State GR is used to provide the match for Medicaid and the federal Mental Health Block Grant.
- Local Funding: Local funds accounted for 2.65% of total NorthSTAR funding in FY 2012. Although the NTBHA is required to contribute a local match for state GR funds and submit that funding to the state, they have been unable to meet the required local match since the NorthSTAR program was established.

Eligibility and Services: ValueOptions is required in their contract to provide services for all Medicaid-eligible individuals and the medically indigent who fall into the priority population. As a result of this contract, there are no waiting lists for services. The number of individuals served in the NorthSTAR service delivery area has increased by 120% since 2000, while funding has only increased by 50%, which has led to a per member funding decrease of 32% over this time period. In order to ensure continued open access for eligible individuals within these budget constraints, ValueOptions has negotiated rate decreases for providers, implemented a "case rate" of \$140 for Medicaid patients and \$100 for medically indigent in order to shift some of the cost risk to providers, and has closed an after hours crisis clinic.⁴⁹

Strengths of the Community Mental Health System

Despite the challenges facing the current system of providing community mental health services in Texas, discussed below, there are also significant strengths on which to build. First, a significant amount of resources are invested in the provision of community mental health services for Medicaid eligible and medically indigent individuals in Texas. In 2009, \$482.6 million in federal and state funds were invested in these services, \$315.6 million of which was state funding.

Second, the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver provides an unprecedented opportunity to improve the mental health system through increased funding for projects that will improve the quality of care, promote recovery, and reduce recidivism in state hospitals and the crisis stabilization system. Third, the current system allows for consistent local input in both the LMHA and the NorthSTAR models. Finally, LMHAs and the NTBHA have excelled at incorporating innovative practices such as telemedicine, the use of peer counselors, and increasing the integration of behavioral and physical health into their systems of care to improve quality of care and contain costs.

Issues Facing Community Mental Health Services

Despite the strengths of the current system of providing community mental health services, there are significant issues surrounding capacity and access to services, service delivery, and outcomes that must be addressed in order to achieve a more sustainable system that provides adequate services in a cost-effective manner that delivers positive outcomes.

Capacity and Access:

- *Straining Other Systems:* Unmet demand for community services strains the resources of jails and hospital emergency rooms, which are ill equipped to provide ongoing, comprehensive mental health services. The strain of caring for the mentally ill detracts from these entities' primary missions of rehabilitating offenders and providing emergency medical attention, respectively.
- *Wait Lists:* Capacity issues exist within our community mental health system, with 8,369 adults and 289 children currently waiting for these services. Although the state has steadily increased funding for community services over the past several sessions, demand has also increased, meaning that per capita funding has stayed relatively level. In other words, the increase in state funding has enabled LMHAs to maintain capacity, but has not expanded capacity in order to reduce the waiting list.
- *Housing and Employment:* A lack of access to supportive housing and supportive employment services exacerbates recidivism rates within both our community and inpatient mental health systems. Many of the individuals who most frequently access state hospital and community services are homeless or at risk of becoming homeless. Without stable living arrangements, individuals with mental illness are unable to focus on recovery and maintaining gainful employment.

Service Delivery:

- *Disjointed System:* Mental health services in the Medicaid program are provided in a piece-meal fashion that is not conducive to streamlined services and lasting recovery for patients. Currently, services such as medication management, counseling and physician services are provided within the standard Medicaid benefit and are available to all Medicaid beneficiaries, while Targeted Case Management and Mental Health Rehabilitation are provided on a fee-for service basis outside of the standard Medicaid benefit and are only available to individuals who fall into the priority population. Additionally, Medicaid eligible individuals may only access Targeted Case Management services through LMHAs.⁵⁰
- *Lack of Physical and Behavioral Integration:* The interconnectedness of physical and behavioral health conditions is well-documented. Individuals with chronic health conditions such as diabetes and heart disease have higher rates of co-morbid behavioral health diagnoses such as depression and anxiety disorders which are shown to exacerbate the physical symptoms of health conditions and increase risk of mortality.⁵¹ Integrating behavioral and physical health services is a nationally-recognized evidence-based best practice that results in lower costs for both types of care, as well as improved health

outcomes.⁵² Although LMHAs are increasingly attempting to integrate behavioral and physical health by co-locating primary care providers in mental health clinics, there is a lack of comprehensive integration between physical and behavioral health. Additionally, the current model of providing some mental health services outside of the standard Medicaid benefit discourages full physical and behavioral health integration. In the NorthSTAR service delivery model, behavioral health services are carved out of the physical service delivery system. This model, under which Medicaid beneficiaries access behavioral health services and physical health services through two different Medicaid benefits managed by different Managed Care Organizations (MCO), creates a barrier to the integration of physical and behavioral health.⁵³

- *Limited Providers:* There is currently a severe shortage of mental health providers in the state, with 68% of Texas counties designated as Health Profession Shortage Areas (HPSAs) for mental health. In 2009, 171 of Texas' 254 counties did not have a single psychiatrist. Adding to this dilemma is the low percentage of physicians in Texas (33%) that accept Medicaid.⁵⁴ Additionally, current practices such as only allowing Medicaid targeted case management to be provided by LMHAs prohibit the entry of willing providers to supply these services.

Outcomes:

- *Outcome Measures not Tied to Payment:* Although LMHAs currently report a significant number of performance and outcome measures to DSHS, the measures are not tied to funding levels. Instead, payments to LMHAs are primarily based on historical funding levels.^[i]

Legislative Budget Board (LBB) Measures: The LBB requires that DSHS capture performance measures such as the number of clients served, the number of hours of services delivered per client, and the number of clients who receive assessments.^[ii] These objective measures capture output rather than quality-based outcomes.

DSHS Measures: As part of their contracts with DSHS, LMHAs must also report clinical outcome and system performance measures not required by the LBB. These measures are based on comparisons between initial client assessments and assessments conducted annually to assess progress.

- Clinical outcome measures are generally subjective and attempt to capture general functioning, engagement in employment and education, criminal justice involvement, and housing. Achieving targets for certain clinical outcomes may result in the waiving of LBB performance requirements for minimum service hours.^[iii]
- System performance measures are generally objective and attempt to capture whether or not financial, quality, and performance measures are being met. Examples of these system performance measures include:
 - Percentage of clients receiving crisis services that are hospitalized in a community or state hospital within 30 days;

- Percentage of clients discharged from crisis services or state hospitals that receive community services within seven days (to capture continuity of care);
- State hospital readmission rate; and
- Percent of clients receiving services within 14 days of their initial assessment.^[iv]

LMHA clinical outcome measures and system performance measures are utilized in risk assessment determinations for heightened oversight and intervention by DSHS. However, actual payments to LMHAs are not dependent on these measures. DSHS is able to levy financial sanctions on LMHAs for failure to meet key performance and outcome measures at six month intervals over each two year contract period. However, the vast majority of the measures upon which sanctions are based are *output-based* measures and *subjective* clinical outcome measures. In order to ensure that the state is getting the best value for our significant investment in community mental health services, *objective quality-based* outcome measures such as the system performance measures included in LMHA contracts must be tied more closely to funding levels.

- *Lack of Transparency:* Despite the significant number of performance and outcomes measures which LMHAs report to DSHS, as discussed above, these figures are not made available to the public, making it difficult for consumers to compare providers. Furthermore, a study conducted by the LBB found that data limitations made it impossible to compare outcomes between the NorthSTAR service area and LMHAs located throughout the state.⁵⁵ To address this, the 82nd Legislature directed DSHS to conduct a comparative analysis of these systems. In order to comply with this directive, DSHS is currently working to implement enhanced assessment data that may allow for more robust comparisons of outcome data across LMHAs and within the NorthSTAR system.⁵⁶
- *Cost Variation:* There is considerable cost variation across LMHAs for providing community mental health services. Per client costs among LMHAs in FY 2011 ranged from \$1,325 to \$4,389.⁵⁷ Although LMHAs serve different patient populations in terms of needs and ability to pay, and there are likely geographical differences in the cost of care, these factors alone do not account for such a large variation in costs.

Potential Solutions to Community Mental Health Services Issues

In order to address these issues, the following potential solutions must be explored:

Maximize Resources: Resources invested in the community mental health services should be used in the most efficient and effective manner possible. Resources should potentially be increased in order to account for population growth and to prevent reliance on jails and hospital Emergency Rooms for mental health services.

Maximize Opportunity Presented by the 1115 Waiver: The state should fully capitalize on the unprecedented opportunity presented by the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver. The waiver provides the potential to improve our mental health infrastructure, increase funding by using local and state funds to draw down additional federal dollars, and integrate physical and behavioral health care. Under the waiver, LMHAs may contribute unmatched Intergovernmental Transfer (IGT) funds, such as local funds and GR used for indigent care, to draw down federal matching funds. Additionally, as public Medicaid providers, the LMHAs may serve as performing providers for approved Delivery System Reform Incentive Payment (DSRIP) projects, which are intended to improve quality of care and transform care delivery systems. Categories of DSRIP projects that have been approved by the federal government offer opportunities to address our community mental health wait list, expand crisis stabilization services, integrate behavioral and physical healthcare, and address the workforce issues within our mental health system.⁵⁸ The 1115 Waiver may also be used to support efforts to expand permanent supportive housing. Although housing will not be allowed as a DSRIP project in and of itself under the waiver, LMHAs may be able to incorporate housing as part of more broad projects aimed at reducing the provision of care in inappropriate settings. DSHS and HHSC should work together to ensure that the 1115 waiver outcome measures for mental health services are consistent with DSHS community mental health outcome measures to ensure consistency across the state's mental health system.

Carve Behavioral Health into Medicaid Managed Care: Mental health services for Medicaid clients should be carved into Medicaid Managed Care in order to ensure that services are delivered in a way that integrates behavioral and physical health, expands the number of providers who offer these services, and provides budget certainty to the state. In carving behavioral health into Medicaid Managed Care, the state must: ensure that Managed Care Organizations (MCOs) use an appropriate and adequate assessment tool to authorize services; establish safeguards which ensure that providers of services to seriously mentally ill patients are well-qualified and are able to provide appropriate behavioral health services; ensure that patients with serious mental illnesses have access to a health home; and ensure that appropriate quality outcomes are measured.

Tie Payments to LMHAs to Outcome and Performance Measures: DSHS payments to LMHAs for community mental health services should be based on a combination of output and quality based objective outcome measures. Additional factors, such as population, poverty levels, geographical differences in the cost of providing care, and variations in the severity of client needs should also be considered in determining funding levels.

Improve Transparency of Outcomes and Performance: The transparency of outcomes and performance within the community mental health system must be increased to improve accountability for funding and to enhance consumers' ability to compare providers. Transparency would be increased by directing DSHS to create a public online public reporting system to allow stakeholders to view and compare community mental health outcome and performance measures across providers. In developing this reporting system, DSHS should use the enhanced community mental health assessment data that results from their work to comply with Rider 65 of the FY 2012-13 General Appropriations Act.

Crisis Stabilization Services

Mental health crisis stabilization services are available to all individuals in the state, regardless of clinical diagnosis or income level. A September 2006 DSHS report ordered by the Legislature found several issues with the crisis service infrastructure in the state including a lag in the delivery of crisis services, a lack of training and competency among crisis service providers, a lack of coordination between law enforcement and LMHAs in responding to mental health crises, and a lack of availability of community resources and crisis alternatives to hospitalization.⁵⁹ In response to these issues, the 80th Legislature appropriated \$82 million to DSHS to implement a comprehensive Crisis Service Redesign (CSR) project aimed at lowering the burden on local communities, law enforcement, and hospitals by ensuring statewide access to crisis stabilization services.⁶⁰

Funding and Services

Since its original investment of \$82 million for the FY 2008-09 biennium, the Legislature has continued to support crisis stabilization services, which are funded using local funds, state GR, and the federal Mental Health Block Grant. This funding has been distributed to LMHAs (including the NTBHA in the NorthSTAR region) to support a variety of services.

Funding Levels: After the original \$82 million appropriation for crisis services in 2007, crisis funding levels were increased to \$165 million for each of the FY 2010-11 and FY 2012-13 biennia.

Services: The majority of the original \$82 million appropriation for CSR was distributed across all LMHAs to (1) increase overall funding to LMHAs that were previously being funded at a lower than average per capita rate, and (2) to establish 24/7 Crisis Hotlines and Mobile Crisis Outreach Teams (MCOT). MCOTs operate in conjunction with crisis hotlines to respond to individuals in crisis in the community, often after a person is detained by law enforcement. Subsequent appropriations have maintained these hotlines and MCOTs.

The remainder of funding is distributed to LMHAs on a competitive basis to LMHAs that are able to contribute at least 25% in matching funds for the development or expansion of local alternatives to incarceration or state hospitalization. This competitive funding has been used to establish:

- Crisis Stabilization Units, which provide immediate access to emergency psychiatric care and short-term residential treatment;
- Extended Observation Units, which provide 24-48 hours of observation and treatment for psychiatric stabilization;
- Crisis Residential Service Units, which provide 1-14 days of crisis services in a clinically staffed residential setting for individuals at risk of harming themselves or others;
- Crisis Respite Service Units, which provide 8-30 hours of short-term crisis care for individuals with a low risk of harming themselves or others;
- Crisis Step-Down Stabilization Units in local hospitals, which provide 3-10 days of psychiatric stabilization in a psychiatrically staffed hospital setting;
- Transitional services, which provide temporary assistance up to 90 days for the homeless, those in need of substance abuse treatment and primary healthcare, those

- involved in the criminal justice system, or those with a high rate of recidivism in state hospitals or other inpatient psychiatric settings; and
- Intensive ongoing services including team-based Psychosocial Rehabilitation services and Assertive Community Treatment (ACT) for high-need adults and intensive, recovery oriented wrap-around services for children.⁶¹

Outcomes: An Evaluation of CSR completed by the Texas A&M University Public Policy Research Institute found that crisis redesign funds improved local crisis infrastructure, consumers of crisis services were more likely to receive treatment in a community setting than an inpatient setting, and direct and measurable cost savings associated with crisis redesign more than cover the cost of the program.⁶² Specifically, a \$1.16 economic benefit was returned for every dollar invested during the first two-years of CSR.⁶³

Crisis Capacity Issues: Demand for crisis service continues to rise, with the number of individuals using crisis services increasing from 30,954 in 2007 to 80,640 in 2011.⁶⁴ Funding for crisis stabilization services should be maintained. Additionally, the state should consider the need for additional resources to meet increased demand. By expanding resources for community services, as discussed previously in this report, the state can provide treatment to individuals in less costly settings and reduce the strain on the crisis system.

Best Practices from Other States

The PCG analysis of the Texas behavioral health system reviewed several promising practices in other states. Examples include utilizing 1915 (i) Medicaid State Plan Amendments to provide permanent supportive housing and translational services to the severely mentally ill in Oregon, Louisiana, and Wisconsin, utilizing 1115 Transformation Waiver authority to provide behavioral health services to an expanded population in Arizona, and providing enhanced payments to community providers based for exceptional outcomes in Oklahoma.⁶⁵ The state should consider the experiences of these states as it considers pursuing similar initiatives, and should continue to look to other states for innovative ideas to improve the delivery and cost-effectiveness of mental health services in Texas.

Section III: Conclusion

The public mental health system in Texas is extremely complex and resource-intensive. Although the state has consistently invested significant funds into this system, many issues remain including issues related to capacity in our state hospitals, access to services, an aging hospital infrastructure that is costly to maintain, a disconnect between payments for indigent care and outcomes among our community providers, and a model of delivering community services to Medicaid-eligible individuals that limits the number of providers in the system, discourages integration of physical and behavioral health, and fails to deliver care in the most cost effective manner. The state can address these issues by fully utilizing available federal funds, redesigning our delivery system for community Medicaid services, exploring alternative options for inpatient care, seeking to better tie outcomes to payments, and exploring opportunities to provide more intensive outpatient support services to avoid hospitalization.

Section IV: Recommendations

- 1. Carve all behavioral health services into Medicaid Managed Care. When doing so, the state must:**
 - a. Ensure that Managed Care Organizations (MCOs) use an appropriate and adequate assessment tool to authorize services;**
 - b. Ensure that safeguards are in place to ensure that providers of services to seriously mentally ill patients are well-qualified and are able to provide appropriate behavioral health services;**
 - c. Ensure that patients with serious mental illness have access to a health home;**
 - d. Ensure that appropriate quality outcomes are measured; and**
 - e. Recognize the importance of continuing local input.**
- 2. Require that DSHS payments to LMHAs for providing community mental health services be based on objective outcomes.**
- 3. Utilize the 1115 Medicaid Transformation Waiver to the greatest extent possible to enhance mental health services.**
- 4. Direct DSHS to create a public online reporting system of community mental health outcome and performance measures.**
- 5. Explore all options to enhance and expand transitional and permanent supportive housing.**
- 6. Pursue a 1915(i) State Plan Amendment to provide supportive housing to severely mentally ill individuals who have had multiple or extended stays in state hospitals.**
- 7. Consider pursuing a pilot of a jail-based competency restoration program among a small group of forensically committed individuals who would otherwise be restored to competency in a state or community hospital.**
- 8. Pursue an expansion of the Youth Empowerment Services (YES) waiver program to additional areas of the state.**

¹ Public Consulting Group, *Analysis of the Texas Public Behavioral Health System: Report to the State of Texas Health and Human Services Commission and Department of State Health Services*, June, 2012, p115.

² House Bill 1, 82nd Regular Session, 2011 (Pitts/Ogden).

³ *Id.*

⁴ Public Consulting Group, *supra* note 1 at p132.

⁵ Table formed using data provided by Department of State Health Services staff via email, September 26, 2012.

⁶ Information provided by Department of State Health Services staff via email, October 10, 2012.

⁷ Mike Maples, Department of State Health Services, *Testimony before the Senate Committee on Health and Human Services*, Austin, Texas, May 8, 2012, p16-17

⁸ Information provided by Department of State Health Services staff via email, September 28, 2012.

⁹ *Lakey v Taylor Shearer*, Texas Court of Appeals, 3rd District, Austin, November 6, 2008.

¹⁰ Public Consulting Group, *supra* note 1 at p44.

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- ¹¹ Information provided by Department of State Health Services staff via email, October 3, 2012.
- ¹² Department of State Health Services, *Hospital Forensic Capacity*, Nov 9, 2011.
- ¹³ Mike Maples, Department of State Health Services, *supra* note 7, p18.
- ¹⁴ Legislative Budget Board, *Managing and Funding State Mental Hospitals in Texas: Legislative Primer*, January 2011.
- ¹⁵ *Supra* note 11.
- ¹⁶ *Supra* note 8.
- ¹⁷ Information provided by Department of State Health Services staff via email, October 12, 2012.
- ¹⁸ Information provided by Department of State Health Services staff, September 13, 2012.
- ¹⁹ Information provided by Department of State Health Services staff via email, September 27, 2012.
- ²⁰ Department of State Health Services, *Comparison of Competency Restoration Programs*, August 14, 2012.
- ²¹ *Id.*
- ²² Information provided by Department of State Health Services staff via email, October 9, 2012.
- ²³ *Supra* note 17.
- ²⁴ Department of State Health Services, *1915(c) Medicaid YES Waiver Brief*, January 28, 2010. Available at: <http://www.dshs.state.tx.us/mhsa/yes/>.
- ²⁵ Information provided by Department of State Health Services staff via email, October 30, 2012.
- ²⁶ Public Consulting Group, *Analysis of the Texas Public Behavioral Health System: Recommendations for System Redesign*, October 2012, p33.
- ²⁷ Information provided by Department of State Health Services staff via email, October 22, 2012.
- ²⁸ *Id.*
- ²⁹ Department of State Health Services, *Fiscal Year 2014-2015 Legislative Appropriations Request*, August 16, 2012, p357.
- ³⁰ *Supra* note 1 at p83.
- ³¹ Texas Health and Safety Code Section 535.035.
- ³² Information based on conversation with Texas Council of Community Centers, October 5, 2012.
- ³³ Danette Castle, Texas Council of Community Centers, *Testimony before the Senate Committee on Health and Human Services*, Austin, Texas, May 8, 2012, p8.
- ³⁴ *Supra* note 7 at p3
- ³⁵ *Id.*
- ³⁶ *Supra* note 26 at p9.
- ³⁷ *Supra* note 1 at p118.
- ³⁸ *Supra* note 26 at p9.
- ³⁹ *Supra* note 1 at p142.
- ⁴⁰ *Supra* note 1 at p123.
- ⁴¹ *Supra* note 1 at p51.
- ⁴² *Supra* note 1 at p63.
- ⁴³ Legislative Budget Board, *Government Effectiveness and Efficiency Report*, January 2011, p277.
- ⁴⁴ *Supra* note 21.
- ⁴⁵ *Supra* note 1 at p37-38.
- ⁴⁶ *Supra* note 36.
- ⁴⁷ *Supra* note 1 at p34.
- ⁴⁸ Ron Stretcher, North Texas Behavioral Health Authority, *Testimony before the Senate Committee on Health and Human Services*, Austin, Texas, May 8, 2012, p4.
- ⁴⁹ *Id.*
- ⁵⁰ *Supra* note 1 at p 36.
- ⁵¹ Anderson, R., Freedland, K., Clouse, R., and Lustman, P. "The prevalence of co-morbid depression in adults with diabetes: A meta-analysis. *Diabetes Care*", American Diabetes Association, *Diabetes Care*, 2001, 24(6), p1069-1078.
- ⁵² The Lewin Group, *Evaluation of the County Medical Services Program Behavioral Health Pilot Project*, Prepared for CMSP, February, 2011.
- ⁵³ *Supra* note 41 at p18.
- ⁵⁴ Hogg Foundation for Mental Health, *Crisis Point: Mental Health Workforce Shortages in Texas*, March 2011.
- ⁽ⁱ⁾ *Id* at p 9.
- ⁽ⁱⁱ⁾ *Supra* note 7 at p6.

[iii] *Supra* note 7 at p7.

[iv] *Supra* note 7 at p8.

⁵⁵ *Supra* note 36 at p278.

⁵⁶ *Supra* note 7 at p10.

⁵⁷ *Supra* note 1 at p100.

⁵⁸ Health and Human Services Commission, 1115 Waiver Regional Healthcare Planning Protocol 2, October 1, 2010. Accessible at: <http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml>

⁵⁹ Texas A&M Public Policy Research Institute, *Evaluation Findings for the Crisis Services Redesign Initiative: Report to the Texas Department of State Health Services*, January 1, 2010.

⁶⁰ *Supra* note 1 at pp51, 127.

⁶¹ Department of State Health Services, *A brief description of statewide crisis services funded by DSHS and contracted to the Local Mental Health Authorities (LMHAs)*, May 2010. available at:

<http://www.dshs.state.tx.us/mhsacsr/default.shtm>

⁶² *Supra* note 55.

⁶³ *Id.*

⁶⁴ *Supra* note 1 at p98.

⁶⁵ *Supra* note 1 at p176.

Charge #9a- Quality and Efficiency: *Monitor the implementation of initiatives aimed at improving health care quality and efficiency in Texas, including: the transition of Medicaid and CHIP to quality-based payments, establishment of the Texas Institute of Health Care Quality and Efficiency, implementation of the Health Care Collaborative certificate, patient-centered medical home for high-cost populations, development and use of potentially preventable event outcome measures, and reduction of health care-associated infections. Include recommendations on how to improve and build upon these initiatives, including improving birth outcomes and reducing infant and maternal mortality.*

Section I. Background

The 82nd Legislature passed a number of initiatives aimed at improving health care quality and efficiency in Texas. These initiatives were in response to growing concerns that the existing health care delivery system fails to promote high quality, efficient health care, and instead incentivizes overutilization, waste, and even fraud by paying based on the volume of services provided. The Institute of Medicine estimates that 30 percent, roughly \$750 billion, of health care spending in the U.S. in 2009 was the result of unnecessary services, excessive administrative costs, fraud, inefficiencies, prices above competitive benchmarks, and missed prevention opportunities.¹

The Legislature recognized that in order to address these inefficiencies and improve quality of patient care, the state would need to align payment incentives within the health care system, including the Medicaid program, with the outcomes the state wants to achieve - healthier patients and a more efficient health care system.

On May 8, 2012, the Senate Committee on Health and Human Services received updates from the Health and Human Services Commission (HHSC), the Department of Aging and Disability Services (DADS), the Texas Department of Insurance (TDI), and the Office of the Attorney General (OAG) on the agencies' implementation of health care quality and efficiency initiatives. An archived video of the Committee's hearing can be found online:
<http://www.senate.state.tx.us/75r/senate/commit/c610/c610.htm>

This report summarizes the implementation status of major quality and efficiency initiatives passed by the 82nd Legislature and provides recommendations to the 83rd Legislature on improving and building upon these initiatives.

Section II. Analysis

Quality and efficiency initiatives passed last session fall into two broad categories: 1) initiatives that apply to Medicaid and the Children's Health Insurance Program (CHIP), and 2) those that apply to the health care system more generally.

Medicaid/CHIP Quality and Efficiency Initiatives

Medicaid/CHIP Quality-Based Measures and Payments

Like most of the health care system, the Texas Medicaid program and the Children's Health Insurance Program (CHIP) still pay providers based on volume of services (also referred to as "fee-for-service"). In order to transition from a volume-based payment system to a quality-based

payment system, Senate Bill 7 by Senator Jane Nelson (82nd Legislature, 1st Called Session) directed HHSC to develop outcome and process measures that can be used to measure the quality and efficiency of health care services delivered in Medicaid and CHIP. SB 7 required HHSC to consider measures that would address “potentially preventable events” (PPEs). PPEs are undesirable events that occur in the health care delivery system and can be indicators of inefficient care or deficiencies in the quality of care provided.

There are five types of PPEs: potentially preventable admissions, potentially preventable ancillary services, potentially preventable complications, potentially preventable emergency room visits, and potentially preventable readmissions. Table 1 provides definitions for the five types of PPEs.²

Table 1 - Potentially Preventable Events

Potentially Preventable Event (PPE)	Definition
Potentially Preventable Admission (PPA)	An admission of a person to a hospital or long-term care facility that may have reasonably been prevented with adequate access to ambulatory care or health care coordination.
Potentially Preventable Ancillary Service (PPS)	A health care service provided or ordered by a physician or other health care provider to supplement or support the evaluation or treatment of a patient, including a diagnostic test, laboratory test, therapy service, or radiology service, that may not be reasonably necessary for the provision of quality health care or treatment.
Potentially Preventable Complication (PPC)	A harmful event or negative outcome with respect to a person, including an infection or surgical complication that occurs after the person’s admission to a hospital or long-term care facility and may have resulted from the care, lack of care, or treatment provided during the hospital or long-term care facility stay rather than from a natural progression of an underlying disease.
Potentially Preventable Emergency Room Visit (PPV)	Treatment of a person in a hospital emergency room or freestanding emergency medical care facility for a condition that may not require emergency medical attention because the condition could be, or could have been, treated or prevented by a physician or other health care provider in a nonemergency setting.
Potentially Preventable Readmission (PPR)	A return hospitalization of a person within a period specified by HHSC that may have resulted from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up. The term does not include a hospital readmission necessitated by the occurrence of unrelated events after the discharge. The term includes the readmission of a person to a hospital for: <ul style="list-style-type: none"> ○ the same condition or procedure for which the person was previously admitted; ○ an infection or other complication resulting from care previously provided; ○ a condition or procedure that indicates that a surgical intervention performed during a previous admission was unsuccessful in achieving the anticipated outcome; or ○ another condition or procedure of a similar nature, as determined by the Executive Commissioner after consulting with the Medicaid/CHIP Quality-Based Payment Advisory Committee.

PPEs are costly and dangerous:

- In 2005, nearly half (47.2 percent) of the total Medicaid emergency room visits were for non-emergent care that could have been treated in a more efficient health care setting.³
- From 2005 through 2010, \$39 billion of all hospital charges (across all payers) in Texas were for PPAs (hospital admissions) that could have been prevented through outpatient care and treatment compliance.⁴
- According to the federal Centers for Disease Control and Prevention (CDC), health care-associated infections (a type of PPC) are one of the top ten leading causes of death in the U.S., with an estimated 99,000 deaths annually resulting from these infections.⁵

PPRs and PPCs

Although SB 7 generally directed HHSC to consider all PPEs, the bill specifically required a quality based payment adjustment for potentially preventable readmissions (PPRs) and potentially preventable complications (PPCs). To help hospitals prepare for the new payment system, HHSC was required to provide confidential reports to each hospital regarding the hospital's performance on PPRs and PPCs for at least one year prior to any reductions in payments.

PPRs

- HHSC began confidential reporting PPRs to hospitals in January 2011.
- Hospitals have received three reports on PPR performance (FY 2009, 2010, and 2011).
- HHSC estimates that PPRs increased Medicaid hospital costs by \$104.2 million in FY 2011.
- HHSC was required to adjust payments for PPRs by September 1, 2012.
- PPR payment adjustments will become effective April 17, 2013.⁶

PPCs

- HHSC began confidential reporting PPCs to hospitals in November 2012.
- HHSC estimated that PPCs increased Medicaid hospital costs by \$88.7 million in FY 2011. Because managed care clients and newborn and pediatric populations were excluded in FY 2011 (the PPC analytical tool does not capture these populations), the actual cost of PPCs in FY 2011 was likely much larger.
- PPC payment adjustments for PPCs are required by September 1, 2013.⁷

Expansion

HHSC should build upon the PPR and PPC payment initiatives by expanding these efforts to all PPEs. As with all outcome measures, HHSC should ensure that payment adjustments account for patient acuity (severity of illness) and are based on overall performance, not on an individual patient basis.

Quality-Based Payments for MCOs

SB 7 required that the outcome and process measures developed by HHSC be applicable not only to fee for service, but also to managed care. HHSC is required to base a percentage of the premiums paid to a Medicaid or CHIP managed care organization (MCO) on the MCO's performance with respect to the outcome and process measures. In response to this requirement,

HHSC has placed up to 5 percent of each MCO's premium "at-risk." MCOs must meet specific performance measures or lose a portion or all of this 5 percent of premium. If an MCO does not meet the performance measures, the unearned portion of the MCO's premium is reallocated to fund the MCO Quality Challenge Award, a program that provides incentive payments to high performing MCOs.⁸

This MCO quality-based payment initiative addresses the payment from HHSC to the MCO, but does not affect the way MCOs pay Medicaid providers participating in their health plan. A recent survey of Medicaid MCOs indicated that 86 percent of managed care claims are paid to health care providers through the traditional fee-for-service (volume-based) payment model, rather than a quality-based payment system.⁹ To build upon the SB 7 quality-based payments for MCOs, the Legislature should require MCOs to develop quality-based payment systems for their providers.

Another way to build upon MCO quality-based payments is to restructure the MCO auto-enrollment process. Medicaid clients who do not choose a managed care plan are automatically enrolled in a MCO plan by HHSC. Currently, this automatic-assignment is based primarily on MCOs' market share in the client's service area. HHSC should replace the existing auto-enrollment process with one that assigns a larger proportion of Medicaid clients (who have not chosen an MCO) to high performing MCOs.

Medicaid and CHIP Quality-Based Payment Advisory Committee

To assist with HHSC's development of quality-based measures and payment systems, SB 7 established the Medicaid and CHIP Quality-Based Payment Advisory Committee. The Advisory Committee is comprised of various health-care providers, including obstetrician-gynecologists, pediatricians, internal or family medicine physicians, geriatric medicine physicians, and long-term care services providers. The Advisory Committee also has a consumer representative member and a member of the Advisory Panel on Health Care-Associated Infections and Preventable Adverse Events to ensure the two advisory groups' efforts are coordinated.¹⁰

The Advisory Committee held its first meeting on February 29, 2012. At this initial meeting, the Advisory Committee decided to focus the committee's work through three subcommittees based on: 1) the highest cost groups in Medicaid, 2) groups that comprise the greatest volume of the Medicaid population, and 3) using rate setting to effect payment incentives.¹¹

Based on these criteria, the subcommittees have focused on:

- populations who are aged and disabled (highest cost group);
- children and pregnant women (comprise greatest volume of Medicaid population); and
- managed care organization payment structures (rate setting to effect payment incentives).¹²

The Advisory Committee has submitted its recommendations to HHSC regarding quality-based measures and payments for the three areas of focus listed above. HHSC is reviewing the Advisory Committee's recommendations to include in the agency's annual quality-based report discussed below. The Legislature should take the Advisory Committee's recommendations into consideration when determining how to build upon existing quality and efficiency initiatives.

More information regarding the Medicaid/CHIP Quality-Based Payment Advisory Committee is available online: http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/med-chip-qbp/

HHSC Quality-Based Report to the Legislature

HHSC is required to report annually on any quality-based outcome and process measures developed and the agency's progress in implementing quality-based payment systems.¹³

In December 2011, HHSC published its first annual report on Medicaid/CHIP quality-based payment and delivery reforms as required by SB 7. The report is available online: <http://www.hhsc.state.tx.us/reports/2012/Quality-Based-Payment-Report.pdf>. HHSC anticipates that its second annual report, due in December 2012, will include more information about the progress of Medicaid and CHIP quality-based initiatives.¹⁴

Quality-Based Payments for LTSS Providers

Existing quality-based payment efforts have focused on acute care services. However, there are significant opportunities for quality and efficiency improvements within Medicaid LTSS. As such, efforts should be made to develop quality-based payments for LTSS. Similar to PPR and PPC adjustments for hospitals, HHSC should provide confidential reports to Medicaid LTSS providers on PPE performance such as potentially preventable hospital admissions (PPAs), potentially preventable readmissions (PPRs), and potentially preventable emergency room visits (PPVs).

Dual Eligible Integrated Care Project

For individuals eligible for both Medicare and Medicaid, Medicare predominately pays for acute care services while Medicaid covers LTSS. As such, quality improvements that lead to reduced acute care costs result in savings to Medicare, which provides savings to the federal government, not the state. To address this issue, the federal Centers for Medicare and Medicaid Services (CMS) presented states with an opportunity to develop demonstration projects to integrate Medicare and Medicaid services for dual eligible individuals. Participating states will get to keep a portion of the Medicare savings.¹⁵

HHSC submitted an application for the Dual Eligible Integrated Care Project to CMS on May 31, 2012. At the time this report was published, CMS had not issued a decision on the Texas application.¹⁶

Nursing Facility Culture Change

Nationally, there is a culture change movement underway within nursing facilities. Historically, nursing facilities have been task-oriented and driven by schedules. The new model shifts the perception of nursing facilities from a “work site” controlled by nursing facility employees to a residence that individuals with disabilities can call home.¹⁷

Major characteristics of the new nursing facility culture include:

- a home and community environment within the nursing facility;
- a commitment to living environments that nurture, inspire, and create a home-like setting;
- person-centered and person-directed practices;

- an emphasis on an individual’s preferences (e.g., bathing times, bed time, dining choices);
- consideration of the voices of individuals with disabilities regardless of age, medical condition, or limitations; and
- the empowerment and support of direct care workers.¹⁸

In July 2011, in response to the growing culture change movement, DADS established the “Culture Change in Texas Long-Term Care” initiative to support nursing facility providers transitioning from a traditional nursing facility culture to a person-directed or centered culture. Through this initiative, DADS shares evidence-based practices and provides training to nursing facility providers.¹⁹ AARP and other advocates say that culture change models like the Green House Project give residents increased personal attention, and reduce adverse outcomes such as depression, hospitalizations, and bedsores.²⁰ Nursing facilities that have adopted culture change also have decreased staff turnover and higher occupancy rates.²¹ Financing the up-front cost of transitioning to the new culture model continues to be a challenge for nursing facilities.

Quality and Efficiency Initiatives Across All Payers

In addition to transitioning the way Medicaid pays for health care services, a number of initiatives intended to improve health care quality and efficiency across the broader health care system are currently underway.

Texas Institute of Health Care Quality and Efficiency

Senate Bill 7 established the Texas Institute of Health Care Quality and Efficiency (Institute). The Institute provides a forum for experts in the health care field to make recommendations to the Legislature on issues relating to improving the overall quality and efficiency of health care in Texas.

In March 2012, Governor Perry appointed the 15-member Institute board of directors. The Board consists of health care experts including health care practitioners, hospital and health plan administrators, researchers, and attorneys. The Board also includes representatives from state agencies and major university systems serving as ex officio, non-voting members. Dr. Ben Raimer from University of Texas Medical Branch serves as Chair of the Institute.²²

Although SB 7 administratively attached the Institute to HHSC to achieve administrative efficiencies and provide staff support, the Institute is independent of any state agency. Any work products or recommendations deriving from the Institute are reflective of the Institute, not HHSC.

SB 7 required the Institute to discuss and make recommendations to the Legislature on three major areas:

1. improving quality and efficiency of health care delivery;
2. improving reporting, consolidation, and transparency of health care information; and
3. implementing and supporting innovative payment and delivery systems for Health Care Collaboratives (also established by SB 7 and discussed later in the report).²³

At the Board's inaugural meeting in May, the Board divided itself into four work groups to begin work on the Institute's required reports to the 83rd Legislature. The four work groups were:

- Work Group A – Maximizing Benefits of Current Health Care Data: Charged with studying how to improve and best use currently available data, both in the public and private sectors, to address quality, cost, and health outcomes.
- Work Group B – Building the Next Generation Health Data and Information Infrastructure: Charged with studying the future environment of health data and the analytic infrastructure needed to support the future collection, use, and analysis of health data.
- Work Group C – Promoting Efficient and Accountable Health Care: Charged with studying the role of consumer-directed health plans and the role of transparency in providing consumers with the incentives, information, and tools they need to make sound and rational decisions about their healthcare purchases.
- Work Group D – Measuring and Reporting Health Care Quality and Efficiency: Charged with studying how and what type of measures could be reported to consumers to help them make decisions on the quality and efficiency of available health services.²⁴

In early November 2012, the Institute published its draft *Report to the Texas Legislature on Activities to Improve Health Care Quality and Efficiency* for public comment. According to the draft, the Institute plans to submit 25 specific recommendations to the Legislature spanning issues such as the collection and reporting of outcome measures, duplicative or unnecessary data reporting, additional data collection for promoting quality and efficiency, public reporting of certain Medicaid PPEs, and disease management and wellness programs.²⁵

The public comment period ended on November 14th and public comments were discussed at the Board's November 15th public meeting. The draft report is currently undergoing revisions based on the comments received. The Institute plans to have its report finalized and submitted to the Legislature by November 30, 2012.²⁶ The Legislature should take the Institute's recommendations into consideration when determining how to build upon existing quality and efficiency initiatives.

Health Care Collaborative Certificate

When health care providers collaborate, quality and efficiency are improved because care is better coordinated. However, state and federal anti-trust regulations, intended to safeguard against anti-competitive behavior by providers, can also create a barrier to innovative payment and delivery models that promote provider collaboration.

To address this barrier, SB 7 established the Health Care Collaborative (HCC) certificate. HCCs, which can consist of physicians, hospitals, other health care providers, and insurers, will work together to improve health care quality and efficiency. Under the HCC certificate, members of an HCC will be able to negotiate payments with payers as a group with protection from anti-trust regulations. The HCCs will be able to accept payments and distribute those payments within the HCC, allowing for innovative delivery and payment models such as bundled payments.

HCCs will be certified by TDI and must pass anti-trust reviews by both TDI and the OAG.²⁷ HCCs will also be required to undergo anti-trust reviews annually upon renewal.²⁸ To qualify for the HCC certificate, the HCC applicant must demonstrate that:

- 1) the proposed HCC is not likely to reduce competition due to the size or composition of the HCC, and
- 2) the pro-competitive benefits of the proposed HCC are likely to substantially outweigh the anticompetitive effects resulting from increased market power.²⁹

TDI held stakeholder meetings on January 30, 2012 and April 24, 2012.³⁰ Proposed rules for HCCs were published for comment on September 28, 2012. The rules are pending adoption.³¹

Health Care-Associated Infections Reporting

Health care-associated infections (HAIs) are infections acquired in a healthcare setting while receiving treatment for another condition. HAIs may be caused by infectious pathogens such as bacteria, fungi, and viruses.³² SB 288 by Senator Jane Nelson (80th Legislature) required hospitals and ambulatory surgical centers to report health care-associated infections (HAIs) to the Department of State Health Services (DSHS). SB 288 also required DSHS to make the HAI rates of facilities available to the public online.

Before the Texas HAI reporting system was implemented, the federal Centers for Disease Control and Prevention (CDC) developed a secure, internet-based reporting system called the National Healthcare Safety Network (NHSN).³³ However, in order to utilize NHSN to implement the Texas HAI reporting requirement, DSHS needed additional statutory authority. Last session, SB 7 made the necessary statutory changes to allow DSHS to designate NHSN as the HAI reporting system for Texas.³⁴

Initial HAI reporting began in October 2011. Additional reporting requirements were phased-in in January 2012. The third phase of HAI reporting will begin in January 2013. Facility HAI rates should be available to the public online by late November or early December 2012.³⁵ More information about the HAI reporting initiative is available online:

http://www.dshs.state.tx.us/idcu/health/infection_control/hai/

Birth Outcomes and Infant and Maternal Mortality

Birth Outcomes and Infant Mortality

Preterm births in Texas increased slightly from 2000 (12.6 percent) to 2010 (13.2 percent). Texas' rate is higher than the national rate of 12 percent for 2010. Babies born preterm often have a low birth weight and are underdeveloped, placing these babies at a greater risk for adverse health outcomes, including death.

Infant mortality rate has remained relatively stable both nationally and in Texas. In 2010, the U.S. infant mortality rate was 6.2 deaths per 1,000 live births. That same year, the Texas infant mortality rate was 6.1 deaths per 1,000 live births.

Both DSHS and HHSC have initiatives underway to reduce preterm births and infant mortality.

Healthy Texas Babies Initiative

To reduce preterm births and infant mortality statewide, the Healthy Texas Babies initiative was established at DSHS. The 82nd Legislature appropriated \$4.1 million for Healthy Texas Babies for the fiscal years 2012-2013.³⁶ The funding is being used to support local initiatives aimed at reducing factors that are known to cause unhealthy birth outcomes (e.g., poor pre-pregnancy health, lack of prenatal care, smoking, poor nutrition, and preterm elective induction before 39 weeks).³⁷ More information about the Healthy Texas Babies initiative is available online: <http://www.dshs.state.tx.us/HealthyTexasBabies/home.aspx>

On November 16, 2012, DSHS announced the launch of a new campaign through the Texas Healthy Babies Initiative to reduce infant deaths and preterm births in Texas by promoting healthy lifestyles *before* pregnancy. According to Dr. David Lakey, Commissioner of DSHS, “living a healthy lifestyle before pregnancy can be critical to the health of the baby.” The Someday Starts Now campaign offers resources to those who may decide to have a baby one day. Those resources include a website containing downloadable tools that help women set health goals and work toward achieving them, allow parents-to-be to create a birth plan, and a guide for new dads. The website also offers information and tips to help future parents start making healthy life choices before starting a family. The campaign also includes outreach events in the community and resources for providers.³⁸

More information about the Someday Starts Now campaign is available online: www.SomedayStartsNow.com

Medicaid Non-Payment for Elective Deliveries Prior to 39 Weeks

In an effort to reduce preterm births and improve birth outcomes, the Texas Medicaid program has changed its policies relating to payment for elective inductions prior to 39 weeks. Beginning October 1, 2011, HHSC discontinued Medicaid payments for non-medically necessary delivery prior to 39 weeks.³⁹

According to HHSC testimony during the committee’s May 8th hearing, the policy seems to be working. Medicaid neonatal intensive care unit (NICU) use has decreased since implementation of the payment change. In addition to improved birth outcomes, this initiative reduces Medicaid costs related to deliveries. It costs the state 18 times more to care for a premature infant in the NICU as compared to the cost of a healthy infant. The average cost for a normal delivery is \$2,500 compared to \$45,000 for an infant who has to go to the NICU.⁴⁰

Maternal Mortality

Maternal mortality in Texas has increased almost three-fold in the last decade, from 8.3 deaths per 1,000 live births in 2000 to 24.6 deaths per 1,000 live births in 2010. Nationally, the maternal mortality rate has doubled over the last decade. These figures are likely conservative estimates because maternal mortality rates are believed to be underreported. Experts do not yet know the cause of this increase.⁴¹ The Healthy Texas Babies committee is developing a plan for a maternal mortality review board.⁴²

In light of dramatic increases in maternal mortality rates in Texas over the last ten years, DSHS should continue to acquire a better understanding of the causes of this increase.

Patient Risk Identification

Hospitals use colored wristbands to identify patient risks (e.g., allergies, fall risk). The specific colors assigned to risk groups varies among hospitals, which increases the potential for medical errors, especially because health care providers may practice in more than one hospital. SB 7 required DSHS to establish a statewide patient identification (wristband) system. DSHS created an ad hoc committee to assist with establishing a statewide wristband system.

The ad hoc committee adopted the three colors supported by the American Hospital Association:

- Red – stop to check medical record for food, medication, or treatment allergies
- Yellow – patient must be assisted when walking or transferring to prevent a fall
- Purple – check the patient’s record for end-of-life patient directives

There are also two colors that are recommended, but optional:

- Green – patient has latex allergy
- Pink – patient has a restricted extremity (patient’s arm cannot be used for drawing blood or obtaining intravenous access)

The ad hoc committee determined that hospitals should adopt their own standards regarding the allowance of social cause wristbands and patients’ rights to refuse to wear a patient risk identifier wristband.⁴³

DSHS published proposed rules in September 2012 and held a stakeholder meeting to discuss the rules on October 25th. DSHS is currently reformulating the rules based on stakeholder comments.⁴⁴ Hospitals will have six months to implement the standardized risk identification system after final rule adoption.

Section III. Conclusion

The 82nd Legislature passed a number of initiatives aimed at improving the quality and efficiency of health care in Texas, both in Medicaid/CHIP and across the health care system more generally. To move the state further in its transition to high quality, efficient health care, the Legislature should continue to build upon these initiatives. This report has presented several opportunities and forthcoming reports by the Medicaid/CHIP Quality-Based Payment Advisory Committee and the Texas Institute of Health Care Quality and Efficiency will present the Legislature with additional recommendations that the 83rd Legislature should give consideration.

Section IV. Recommendations

Medicaid

- **HHSC’s quality-based outcome measures and payments should address all of the potentially preventable events (PPEs).**
- **HHSC's performance reports to hospitals should include all PPEs.**

- **HHSC's outcome measures should be risk-adjusted and allow for rate-based performance among health care providers.**
- **Managed care organizations should develop quality-based payment systems for compensating health care providers.**
- **HHSC should develop an auto-enrollment process that recognizes high performing MCOs by assigning a higher proportion of auto-enrollees to that MCO.**
- **The Legislature should consider the Medicaid/CHIP Quality-Based Payment Advisory Committee's recommendations.**
- **HHSC and DADS should continue to improve the coordination of acute care services and LTSS.**
- **HHSC should develop and implement quality-based payment systems for Medicaid LTSS providers designed to improve quality of care and reduce the provision of unnecessary services.**
- **HHSC should provide confidential reports to Medicaid LTSS providers on PPE performance such as potentially preventable hospital admissions (PPAs), potentially preventable readmissions (PPRs), and potentially preventable emergency room visits (PPVs).**

All Payers

- **The Legislature should consider recommendations by the Texas Institute of Health Care Quality and Efficiency.**
- **The Legislature should consider strategies to improve birth outcomes and reduce infant mortality currently being developed by HHSC and DSHS.**
- **DSHS should seek to better understand the possible causes of increased maternal mortality in Texas.**

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- ¹ Institute of Medicine, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, 2012.
- ² Senate Bill 7 by Senator Jane Nelson passed by the 82nd Legislature (1st Called Session).
- ³ Health and Human Services Commission, *Copays for Non-emergent Use of Hospital Emergency Rooms: Cost Effectiveness and Feasibility Analysis*, May 2008, p14.
- ⁴ Department of State Health Services, *State of Texas Preventable Hospitalizations Profile*, <http://www.dshs.state.tx.us/ph/state.shtm> (Last visited on November 29, 2012).
- ⁵ Agency for Healthcare Research and Quality, *Healthcare-Associated Infections*, <http://www.ahrq.gov/qual/hais.htm> (Last visited on November 29, 2012).
- ⁶ Health and Human Services Commission, *Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal Year 2011*, November 2012, <http://www.hhsc.state.tx.us/reports/2012/PPR-Readmissions-FY2011.pdf>.
- ⁷ Health and Human Services Commission, *Potentially Preventable Complications in the Texas Medicaid Population, State Fiscal Year 2011 (Fee-for-Service and Primary Care Case Management)*, November 2012, <http://www.hhsc.state.tx.us/reports/2012/PPC-Complications-FY-2011.pdf>.
- ⁸ Health and Human Services Commission, *Texas Medicaid Managed Care Quality Strategy 2012-2016*, p15.
- ⁹ Health and Human Services Commission background document on quality committees, received October 26, 2012.
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- ¹¹ Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services (Panel 1)*, May 8, 2012, p5.
- ¹² *Id.*
- ¹³ *Supra* note 11 at p4.
- ¹⁴ Health and Human Services Commission, *Quality-Based Payment and Delivery Reforms in Medicaid and the Children's Health Insurance Program Annual Report*, December 2011.
- ¹⁵ Health and Human Services Commission, *Texas Dual Eligible Integrated Care Project*, <http://www.hhsc.state.tx.us/medicaid/dep/index.shtml> (Last visited November 29, 2012).
- ¹⁶ *Id.*
- ¹⁷ Department of Aging and Disability Services, *Culture Change in Texas Long-Term Care*, <http://www.dads.state.tx.us/culturechange/library/whatis.html> (Last visited November 29, 2012).
- ¹⁸ *Id.*
- ¹⁹ Letter from Commissioner Chris Traylor to Nursing Facilities, *Culture Change Initiative*, July 20, 2011, <http://www.dads.state.tx.us/culturechange/library/commissionermemo.pdf>.
- ²⁰ Schorn, Tracy Sutton, *A Homey Nursing Home*, AARP Bulletin, May 2012.
- ²¹ *Supra* note 19.
- ²² Texas Institute of Health Care Quality and Efficiency, *Draft Report to the Texas Legislature on Activities to Improve Health Care Quality and Efficiency*, November 9, 2012, p2.
- ²³ Health and Human Services Commission, *Testimony before the Senate Committee on Health and Human Services (Panel 2)*, May 8, 2012, p4.
- ²⁴ *Supra* note 22.
- ²⁵ *Id.* at p26-36.
- ²⁶ *Id.* at p40.
- ²⁷ Office of the Attorney General, *Testimony before the Senate Committee on Health and Human Services*, May 8, 2012, p7.
- ²⁸ Texas Department of Insurance, *Testimony before the Senate Committee on Health and Human Services*, May 8, 2012, p5.
- ²⁹ *Supra* note 27 at p6.
- ³⁰ *Supra* note 28 at p3.
- ³¹ Texas Department of Insurance, *Proposed and Adopted Rules for 2012*, <http://www.tdi.texas.gov/rules/2012/parules.html> (Last visited November 29, 2012).
- ³² Department of State Health Services, *Health Care-Associated Infections*, http://www.dshs.state.tx.us/idcu/health/infection_control/hai/ (Last visited November 29, 2012).

³³ Centers for Disease Control and Prevention, *National Healthcare Safety Network*, <http://www.cdc.gov/NHSN/> (Last visited November 29, 2012).

³⁴ *Supra* note 23 at p12.

³⁵ *Id.* at p12-13.

³⁶ *Id.* at p18.

³⁷ Department of State Health Services News Release, *Texas Launches New Campaign to Reduce Infant Deaths*, November 15, 2012, <http://www.dshs.state.tx.us/news/releases/20121115.aspx>.

³⁸ *Id.*

³⁹ *Supra* note 23 at p19-20.

⁴⁰ Health and Human Services Commission News Release, *Medicaid Initiative Seeks to Reduce Risk of Premature Births*, July 3, 2012.

⁴¹ *Supra* note 23 at p22.

⁴² *Id.* at p23.

⁴³ *Id.* at p11.

⁴⁴ Information provided by Department of State Health Services via e-mail November 29, 2012.

Charge #9B- Federal Flexibility: *Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services and make recommendations for any legislation needed to improve, enhance, and/or complete implementation, including but not limited to:*

- *Federal Flexibility - Monitor implementation of initiatives to increase state flexibility, including the Health Care Compact and the Medicaid Demonstration Waiver;*

Please refer to the Medicaid Reform Waiver Legislative Oversight Committee report. This report can be found online at:

<http://www.senate.state.tx.us/75r/senate/commit/c885/downloads/c885.InterimReport82.pdf>.

Charge #9C- Foster Care Redesign: *Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services, 82nd Legislature, Regular and First Called Session, and make recommendations for any legislation needed to improve, enhance, and/or complete implementation, including but not limited to:*

- *Foster Care Redesign - Monitor implementation of the initiative to redesign the foster care system.*

Section I. Background

After much planning, collaboration, and preparation, foster care redesign is in its initial phases with rollout planned for the summer of 2013. The need for foster care redesign sprung from children and youth being too often placed outside of their home communities, away from family, friends, schools, church homes, and support systems; a current imbalance in geographic distribution of services and providers; and an insufficient number of residential providers that offer a full continuum of services for children with varying levels of needs.¹

The goal of foster care redesign is to improve outcomes for children, youth, and families by creating sustainable placement resources in communities that will meet the service needs of children and youth in foster care, using the least restrictive placement settings.² Through foster care redesign the Department of Family and Protective Services (DFPS) wants to promote positive outcomes for children, youth, and families; improve the overall process and quality of care; and align incentives with process and quality indicators in a manner that encourages the development of services in locations where they are needed.³

Foster Care Redesign was authorized by the 82nd Legislature through House Bill (HB) 1, DFPS Rider 25 and Senate Bill (SB) 218. Rider 25 required DFPS to submit a report summarizing the expenditures for foster care redesign and progress toward achievement of improved outcomes for children, youth, and families based on the quality indicators. A copy of the report can be found online at http://www.dfps.state.tx.us/About_DFPS/Legislative_Presentations/DFPS/rider.asp.

Section II. Analysis

The Foster Care Redesign Model

Model Development and Stakeholder Input

In January of 2010, DFPS began developing a foster care redesign model. To ensure adequate stakeholder input, DFPS created a Public Private Partnership (PPP) to serve as the guiding body during the process. The PPP consisted of a wide range of representatives including child placing agencies (CPAs), Court Appointed Special Advocates (CASA), family law judges, and foster youth.⁴ Additionally, DFPS created an open forum for public input around the state by conducting regional and statewide community forums and stakeholder surveys, attending trade association and Youth Leadership Council meetings, and drafting a Request for Proposal (RFP) for comment.⁵ Based on PPP and stakeholder input and an evaluation of foster care redesign models in other states, DFPS submitted a foster care redesign report to the Legislature in January 2011.⁶

This body has provided valuable input not only during the initial development phase, but also during the implementation of foster care redesign. The individuals serving on this committee have the background and experience needed to provide thoughtful feedback to DFPS moving forward. DFPS should ensure the PPP remains a guiding body throughout all stages of implementation

Model Design

Single Source Continuum Contractor

Under Foster Care Redesign, DFPS will contract with a single provider to provide services throughout an entire geographical area, or "catchment area." This provider, known as a Single Source Continuum Contractor (SSCC), may serve as the sole provider of services, subcontract out all services, or both provide and subcontract out services. As a result, DFPS will only have one contract in each catchment area, rather than a multitude of providers through multiple contracts, which will create a more streamlined process.⁷

Each catchment area must be large enough to have at least 500 new entries of children in paid foster care annually. The SSCC is responsible for improving outcomes for local children, youth, and families who originate from within the designated catchment area. The SSCC must demonstrate that stakeholders and the community in the catchment area support the implementation of the redesigned model in an effort to ensure that the local community and stakeholders are invested in foster care redesign and will wrap around the children in foster care in their home community.⁸

The foster care redesign model consists of three major changes to the foster care system:

1. Competitive Contract Procurement

Currently, DFPS procures foster care services through an open enrollment process, which allows any willing provider to provide foster care services.⁹ Under this model, the supply of providers dictates the foster care infrastructure without regard to where and what kinds of services might be needed most. This may lead to children being placed outside of their home community away from their school, siblings, and other family members.

In contrast, under the new redesigned system, DFPS will procure services through a competitive process, requiring the SSCC to ensure the foster care infrastructure meets the needs of the children in the catchment area. Because this model allows the needs of the system to dictate the infrastructure, it should lead to improved outcomes based on children being placed in their home communities.

2. Performance-based Contracts

DFPS currently reimburses providers of foster care services based on the amount of services delivered, without regards to the quality of those services. For example, a CPA could move a child between multiple placements, creating a negative impact on the child, yet still receive the same reimbursement as keeping the child with one stable provider.

Under the redesigned system, DFPS will shift to using performance-based contracts that will focus on outcomes and quality of services and will eventually reimburse the contractor based on outcomes achieved, like permanency, as opposed to services provided.¹⁰ DFPS has developed performance measures that correspond to the eight Quality Indicators set out in SB 218, which DFPS will use to assess the SSCC's attainment of positive outcomes and quality service provision (see Table 1).

Table 1. Quality Indicators and Related Performance Measures¹¹

Quality Indicator	Performance Measure
Children are safe from abuse and neglect in their placements.	Percent of children who do not experience an incidence of abuse, neglect, or exploitation while placed with the SSCC.
Children are placed in their home communities.	Percent of children placed within 50 miles of their home.
Children are appropriately served in the least restrictive environment that supports minimal moves.	Percent of children with no placement changes in the previous 12 months, counting only the changes that occurred while placed with the SSCC. Percent of children in foster care placed in a foster family home.
Connections to family and others important to the child are maintained.	Percent of children in foster care who have at least one monthly personal contact with a family member, who is not a parent or sibling or with another person who has a significant, long-standing relationship with the child or child's family and is identified as appropriate by DFPS. Percent of children in foster care who have at least monthly personal contact with each sibling in foster care.
Children are placed with siblings.	Percent of cases where all siblings are placed together.
Services respect the child's culture.	SSCC's contract will have Cultural Competency terms and conditions.
Children are fully prepared for successful adulthood, through being provided opportunities, experiences, and activities similar to those experienced by their non-foster care peers.	Percent of youth in foster care who have a regular job at some time during the year. Percent of 17-year-old youth who have completed PAL Life Skills Training. Percent of youth age 16 or older who have a driver's license or state identification card.
Children are provided opportunities to participate in decisions that impact their lives.	Percent of children age 10 or older who participated in any Service Plan meeting. Percent of children who participated in at least one discussion about the child's opinion regarding placement options. Percent of court hearings attended by children age 10 or older.

3. Single Blended Rate

Currently, DFPS pays for foster care services based on the individual needs of a child, providing higher reimbursement for higher needs children. For example, the daily

reimbursement rate for a CPA foster home providing services for a child needing a moderate service level is \$71.91, yet \$175.66 for an intense service level.¹²

If a provider is able to lower a child's level of need under the current system, the provider will actually be penalized by a lower reimbursement, instead of rewarded for improving outcomes. The current system offers no financial incentive to lower a child's level of need.

The redesigned model attempts to address this issue by creating a single blended rate to create a financial incentive to improve the well-being of children in care, reduce their lengths of stay, and increase quality outcomes.¹³

Implementation Timeline

DFPS plans to implement FCR as follows:

- **Start-Up Phase:** After contract execution there is a start-up period that will last up to six months in which DFPS and the SSCC will work together to develop a way to address any implementation issues. The SSCC will develop a continuum of care network with local service providers and submit operations, management, and community engagement plans to DFPS for approval. The SSCC will work to create an adequate provider network.
- **Stage I:** The first stage of implementation will focus on improving child well-being and permanency outcomes by focusing on developing infrastructure to support services, reducing the number of moves children experience, offering services to children in their home communities, and improving quality of services to children.
- **Stage II:** The second stage of implementation will aim to improve the rate at which safe family reunification occurs. In addition to continued improvements to areas of focus in Stage I, Stage II will focus on collaborative service planning and supporting infrastructure and quality of services for families of children in foster care.
- **Stage III:** The third stage of implementation will focus on reducing the length of time, on average, that children spend in paid foster care, in addition to continued improvements to areas of focus in Stages I and II.

To-date, DFPS has not yet entered the Start-Up Phase, but has begun to implement foster care redesign as follows:

- **SSCC Awards:** On June 20, 2012, DFPS made tentative SSCC awards to:
 - Providence Services Corporation of Texas (Providence): non-metropolitan catchment area - DFPS administrative Regions 2 and 9 together, and
 - Lutheran Social Services of the South (Lutheran): metropolitan catchment area - DFPS administrative Region 11.
- **Lutheran Contract Terminated:** During the contract negotiations period that followed the tentative contract awards, Lutheran became ineligible for a SSCC contract due to a corrective action imposed by the licensing division of DFPS. At this time, DFPS is placing Foster Care Redesign on hold in Region 11 or any metropolitan catchment area until a meeting with the PPP in late November 2012 to seek guidance on how to move forward.
- **Providence negotiations:** At the time of this report, DFPS was continuing negotiations with Providence to be concluded in November 2012. If negotiations are successful, DFPS will execute a final contract with Providence and enter into the Start-Up Phase, as

outlined above, in January 2013 to collaboratively develop joint operational protocols that address implementation issues unique to the Region 2/9 catchment area.

No foster care placement referrals will be made by DFPS to Providence until Providence demonstrates, through a detailed assessment process, its readiness to accept and manage referrals. If Providence requires a full six month Start-Up Phase, an initial foster care placement referral will not occur until July 2013.

As permitted under foster care redesign, Providence will both directly provide services and work with subcontractors in Region 2/9. During the hearing process, some expressed concerns with allowing the SSCC to directly provide services, which could be perceived as a conflict of interest. To ensure there is no conflict of interest, there are certain safeguards built into foster care redesign. The SSCC is required to serve all of the children in the catchment area and is financially responsible for ensuring quality outcomes are achieved, regardless of the provider. Additionally, DFPS will retain the role of case management to ensure proper oversight for each child in the foster care system.

Another sentiment expressed during the hearing process was a concern that the SSCC could place children back with their parents too quickly or expedite adoption to receive incentive payments. Again, there are safeguards built into foster care redesign to address this concern. As the case manager, DFPS will maintain oversight on each case. DFPS will also monitor re-entry rates of children into foster care after receiving SSCC services and exiting to a placement that was intended to be permanent. Additionally, the court will have final approval over placement and permanency decisions, preventing the SSCC from making decisions that are not in the child's best interest. To the extent possible, the SSCC should be included in the court process to ensure all parties are held accountable.

Ongoing Assessment and Oversight

In general, to ensure adequate oversight of the SSCC, DFPS will:

- Regularly track, monitor, and report key performance measures;
- Maintain a Data Dashboard to aggregate information and performance measure outcomes, providing both transparency and opportunities to evaluate the success of the SSCC;
- Create opportunities for communication between DFPS and the SSCCs at the local, regional, and state levels; and
- Offer technical assistance when needed.

During the initial rollout, DFPS will evaluate the foster care redesign model to ensure it is viable and presents improved outcomes for children. As part of the evaluation, DFPS should compare outcomes in the foster care redesign model with outcomes in the current foster care system. Additionally, DFPS should publically display the outcome data on its website to promote public accountability and transparency.

DFPS will also work to identify any improvements needed in the model's structure; ensuring safe, appropriate placements; and continuing to engage a broad community of stakeholders.

Although there is a clear need for DFPS oversight of the SSCCs to ensure children are safe and protected, DFPS must balance this need for oversight with a sufficient amount of flexibility to allow the SSCC to achieve foster care redesign outcomes. DFPS will continue to monitor and modify the SSCC's contract as necessary throughout the implementation phases. Staged implementation will allow DFPS to have the opportunity to assess SSCC readiness prior to granting additional service responsibilities to individual SSCCs and expanding foster care redesign into other catchment areas.

Grievance Process

DFPS will require the SSCC to develop and implement a process by which children, families, and Subcontractors may raise concerns about the provision and/or quality of services provided and contract disputes. DFPS will review these processes and evaluate the timeliness and appropriateness of response through its contract management and monitoring function. The Office of Consumer Affairs will serve as a neutral party in reviewing case-specific complaints.

Cost Neutral

According to HB 1, DFPS Rider 25 from the 82nd Legislature, foster care redesign cannot result in expenditures that exceed the amounts appropriated by the Legislature for foster care and other purchased services in Fiscal Years 2012-2013, with the exception of expenditures for normal entitlement caseload growth. It is imperative foster care redesign abide by this requirement and stay cost neutral to ensure all other resources at DFPS continue to be directed toward their appropriated purposes.

Section III. Conclusion

Although there is still a significant amount of work to be done to fully implement foster care redesign, with the coordinated efforts of the state, communities, and stakeholders, foster care redesign has the potential to substantially improve the quality of care, including increased permanency placements, for children in the foster care system.

Section IV. Recommendations

- 1. The state, communities, and stakeholders should continue to coordinate efforts to ensure the complete implementation of foster care redesign.**
- 2. Foster care redesign must be implemented in a cost neutral manner to ensure all other resources at DFPS continue to be directed toward their appropriated purposes.**
- 3. DFPS should continue to use the PPP as a guiding body in foster care redesign implementation.**
- 4. DFPS should use existing resources to publically display the foster care redesign outcome data on its website to promote public accountability and transparency.**

¹ Howard Baldwin, Department of Family and Protective Services, *Testimony before the Senate Committee on Health and Human Services*, Austin, Texas, March 21, 2012, p. 3.

² *Id.* at p. 2.

³ Department of Family and Protective Services, *Legislative Briefing*, Austin, Texas, April 25, 2012, p. 2.

⁴ *Supra* note 1 at p. 6.

⁵ *Id.*

⁶ See Improving Child and Youth Placement Outcomes: A System Redesign Report, January 2011, http://www.dfps.state.tx.us/documents/Child_Protection/pdf/2011-02-14_FosterRedesignReport.doc (Last accessed November 28, 2012).

⁷ *Supra* note 3 at p. 12.

⁸ *Id.* at p. 20.

⁹ Information provided by Department of Family and Protective Services staff via email, June 21, 2012.

¹⁰ *Supra* note 1 at p. 8.

¹¹ Information provided by Department of Family and Protective Services staff via email, June 21, 2012.

¹² Health and Human Services Commission letter to the Legislative Budget Board, April 16, 2012.

¹³ *Supra* note 10.

Charge #9D- State Supported Living Centers: *Monitor implementation of the U.S. Department of Justice (DOJ) settlement agreement to address State Supported Living Center concerns.*

Section I. Background

In March 2005, the U.S. Department of Justice (DOJ) began investigating Texas' state supported living centers (hereinafter referred to as "SSLCs" or "centers," formerly termed "state schools") following reports of widespread abuse, neglect and even residents' deaths. In December 2008, the DOJ issued its findings, including serious deficiencies due to failure to protect residents from harm; inadequate medical and behavioral health services; improper use of restraints; and failure to provide services in the most integrated setting appropriate to residents' needs. The Department of Aging and Disability Services (DADS) implemented a corrective action plan and in May 2009, Texas and the DOJ entered into a five-year settlement agreement. The settlement agreement requires independent monitors, enhanced efforts to detect and deter abuse, and improvements to the level of care for Texans with intellectual and developmental disabilities.

In addition to the DOJ settlement agreement, the 81st Legislature implemented a number of sweeping reforms concerning Texas' SSLCs and services for individuals with intellectual and developmental disabilities. These reforms include Senate Bill 643 (Nelson/Rose) and the 2010-11 General Appropriations Act (Article II, Special Provisions, Section 48, Senate Bill 1, 81st Legislature, Regular Session, 2009) (hereinafter referred to as "Rider 48"). The 82nd Legislature continued its commitment to SSLCs with increased funding for SSLCs through the 2012-13 General Appropriations Act.

In Texas, SSLCs are included in the array of services available to individuals with intellectual and developmental disabilities. Texas' 13 SSLCs are operated by DADS and provide around the clock residential services, treatment and healthcare for individuals with intellectual and developmental disabilities who are medically fragile or who have behavioral health issues. SSLC residents have varying disabilities and functional levels, ranging from mild to profound. A number of residents have medically complex issues or profound behavioral health issues, requiring assistance at mealtimes and frequent monitoring, while others are relatively independent and require minimal assistance. As of September 2012, 3,774 individuals resided at a SSLC.¹ Figure 1 includes a map of Texas' 13 SSLCs.

Figure 1. Texas State Supported Living Centers²



Section II. Analysis

Implementation of Department of Justice Settlement Agreement

The 81st Legislature approved the system wide settlement agreement reached in May 2009 between Texas and the DOJ as a result of the DOJ's investigation of Texas' SSLCs via SCR 77 (Nelson, 81R).³ In brief, the settlement agreement requires independent monitors, enhanced efforts to detect and deter abuse, and improvements to the level of care for Texans with intellectual and developmental disabilities. To end the settlement agreement, each individual SSLC must be in substantial compliance in each of the 20 targeted improvement areas (see below for more information) for three consecutive monitor visits. Each SSLC is evaluated and may exit the agreement on an individual basis. The settlement agreement is available online at http://www.justice.gov/crt/about/spl/documents/TexasStateSchools_settle_06-26-09.pdf.

Timeline

Under the settlement agreement, three independent monitors were selected and each monitor established a team. The monitors and their teams conducted baseline reviews at each of the 13 SSCLs from January through May of 2010 to give the monitors and the state an accurate picture of the starting point for each facility and identify areas where service delivery improvements were required. Beginning in July 2010 and continuing to the present, monitors began conducting semi-annual compliance reviews at each of the 13 SSLCs to measure effectiveness of compliance improvement activities. Formal reports of these compliance reviews are issued 45-60 days after completion of the review. Compliance reports can be found at <http://www.dads.state.tx.us/monitors/reports/index.html>. The state is currently in its third year of the settlement and monitors are completing the fifth round of reviews. The term of the current agreement ends in June 2014. Currently, none of the SSLCs have achieved substantial compliance with any area of the settlement.

Settlement Agreement Structure

The settlement agreement is broken down into twenty broad targeted improvement areas (see Table 1), which are further broken down into 161 measureable sub-sections (see Appendix 1). During each semi-annual monitoring visit, the monitoring teams assess services and whether or not each SSLC is in substantial compliance with any of these areas and sub-sections of the settlement. According to the terms of the settlement agreement, the monitors may only rate the facilities in one of two categories: substantial compliance or noncompliance. The monitors will rate a facility at noncompliance until evidence exists to support substantial compliance for one year. No provisions were made for intermediate ratings, such as partial compliance, progress, or improvement. At this point, no SSLC has met substantial compliance in any of the 20 targeted areas.

Table 1: The Settlement Agreement's 20 Targeted Improvement Areas⁴

- | | |
|--|---|
| • Restraint reduction | • Medical care |
| • Reducing abuse, neglect, and exploitation | • Nursing care |
| • Quality assurance | • Pharmacy services and safe medication practices |
| • Integrated protections, services, treatments, and supports | • Physical and nutritional management |
| • Integrated clinical services | • Physical and occupational therapy |
| • Minimum common elements of clinical care | • Dental services |
| • Identifying and addressing at-risk individuals | • Functional communication therapy |
| • Psychiatric care and services | • Skill acquisition program services |
| • Psychological care and services | • Serving persons in the most integrated setting appropriate to their needs |
| | • Consents to treatment |
| | • Recordkeeping |

Settlement Implementation, Progress, and Positive Practices

Implementation of SB 643, Rider 48, and Increased Appropriations

All of the major provisions of SB 643⁵ have been implemented at this time and have had a positive impact on the safety and well-being of SSLC residents.⁶ These major provisions include video surveillance, FBI fingerprint based criminal background checks, random drug testing, an Office of Independent Ombudsman, an Assistant Commissioner of SSLCs, and serious event definition and notification protocol.

Rider 48 and the 2012-13 General Appropriations Act have increased the amount of appropriations for SSLCs, despite a continually declining population in SSLCs. Specifically, the Legislature appropriated \$1.04 billion in Fiscal Years (FY) 2008-09, \$1.28 billion in 2010-11, and \$1.29 billion in 2012-13.⁷ These increased appropriations have made the implementation of SB 643 and other improvements possible.

Monitoring System

As mentioned above, the current monitoring process only allows the DOJ monitors to identify whether a SSLC is in substantial compliance or not. This "black or white" system does not provide stakeholders or the Legislature a clear understanding of the progress at each individual SSLC or the system in general. Without this understanding, it is also difficult to identify areas for improvement or in need of additional attention and resources.

According to DADS, the DOJ monitors have themselves indicated that the current process is "not a good indicator of progress" and that "merely counting the number of substantial compliance ratings to determine if the facility is making progress is problematic for a number of reasons."⁸

DOJ Narrative

Although the current rating system does not allow the monitors to specifically rate "progress," each compliance report does contain a narrative section in which the monitors have recorded signs of progress toward substantial compliance. Specifically, the narratives provide an overall summary of the SSLC's compliance status, as well as specific information on steps taken to assess compliance, facility self-assessment, summary of monitor's assessment, and recommendations.

DADS Internal Data

DADS has used the information from the narrative sections of the compliance reports to create an internal tracking system to assess progress toward substantial compliance at each facility. This data is able to better identify areas of progress and in need of improvement, focusing on each individual section of the settlement agreement's twenty targeted improvement areas.

DADS provided an example of this data to the Senate Health and Human Services Committee at its July 31, 2012 interim hearing (see Figure 2).⁹ Based on the data, the Legislature was able to better identify and understand the progress DADS has achieved, and where progress is still needed, for all 13 SSLC's in each of the 20 target improvement areas. For example, the data indicates that DADS has made significant progress in the area of protection from harm meeting substantial compliance at a rate of 50% or greater at each SSLC (see Figure 3). Other areas of noted improvements include community transitions, psychiatric services, and pharmacy services. For a full list, see Appendix 2.

Figure 2.¹⁰

State Supported Living Center Compliance Summary
 Department of Justice Settlement Agreement
 Percentage of Requirements Showing Progress or Substantial Compliance
 Total Number of Requirements = 161
 As of November 9, 2012

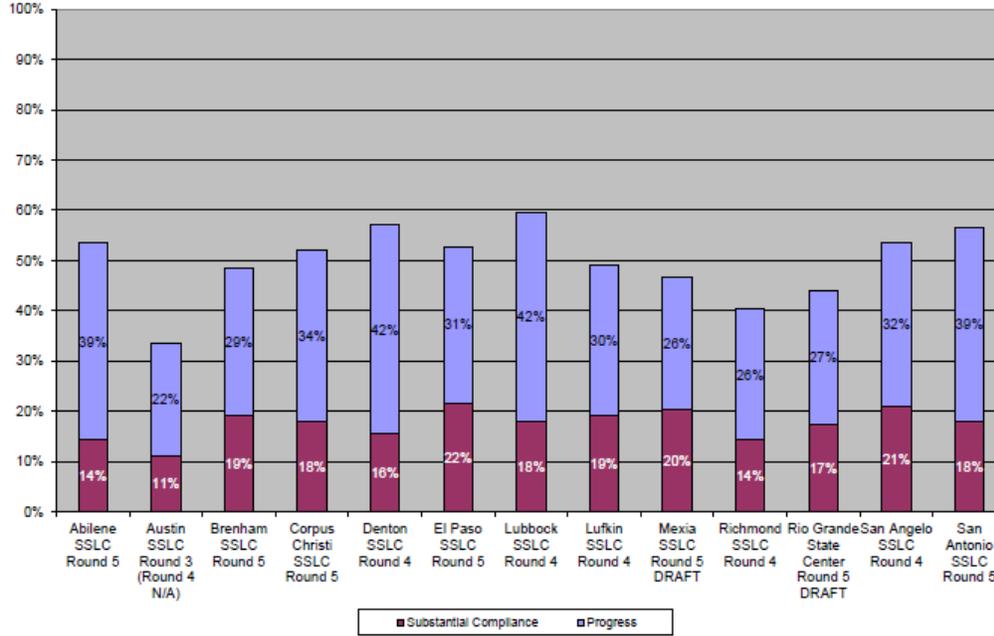
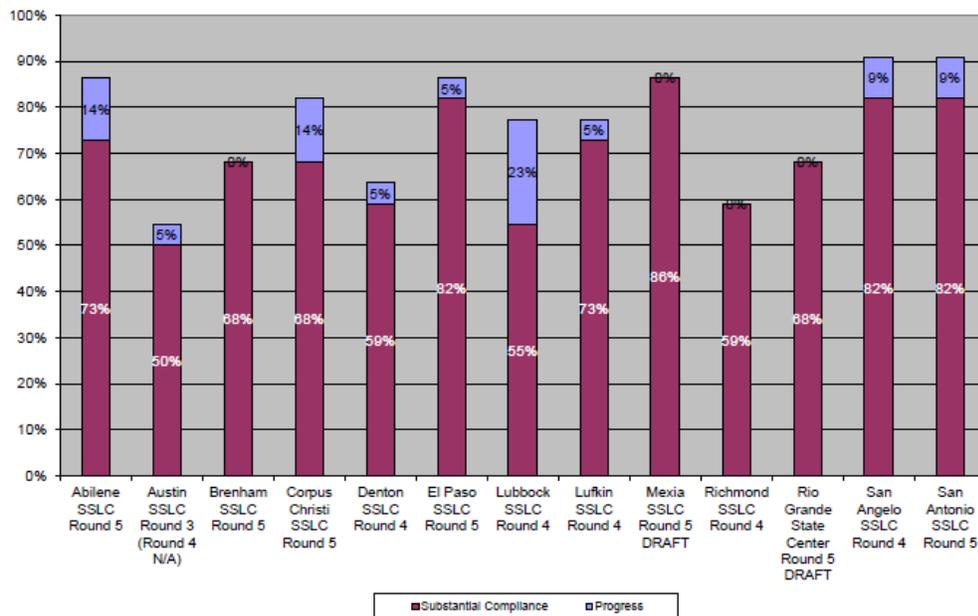


Figure 3.¹¹

State Supported Living Centers
 Department of Justice Settlement Agreement
 Section D - Protection from Harm
 22 Items in this Section
 Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



Looking Forward

While the Legislature recognizes the complexity of the issues facing SSLCs, it also recognizes the urgency. DADS and the Legislature must work together to protect this population, improve our SSLCs, and end the settlement agreement. To reach those goals, DADS must create a comprehensive plan to self-identify the specific actions necessary to reach compliance, keep the Legislature adequately informed of its progress, test new ideas through pilots to potentially expand statewide, and focus on the most critical needs included in the settlement agreement and facing the SSLC system.

Comprehensive Plan of Action

Because of the complexity involved in reaching compliance, DADS must have a well thought out plan of action in order to reach substantial compliance in a timely manner. The plan should include a step-by-step analysis on how best to achieve compliance at each SSLC and in each targeted improvement area, providing a specific course of action that includes performance measures and deadlines to achieve specific goals. On an annual basis, DADS should provide a report to the Legislature outlining the details of the plan.

Reporting to the Legislature

In addition to the annual report listed above, DADS should provide a data analysis on a quarterly basis to the Legislature outlining the progress at each SSLC in each targeted improvement area as shown in Appendix 2.

Pilot Programs

Because there are 13 SSLCs across the state, it can sometimes be difficult for DADS to try new techniques or policies that could have the potential to improve quality of care. To alleviate this problem, DADS should work with individual SSLCs to pilot new techniques, including implementing best practices. Based on the results and expertise gained from the pilot, DADS should consider expanding the techniques and policies across all SSLCs.

Focus on Critical Needs

All twenty sections of the settlement agreement are critical in that they all impact client care; however, certain sections have a much more direct impact on protecting our vulnerable populations. To achieve the most meaningful results, DADS should identify which of the targeted areas are most critical and direct time and resources accordingly. When identifying the most critical areas, DADS should pay particular attention to the following sections:

- (1) *Section C and D, Protection from Harm – Restraints and Abuse, Neglect, and Incident Management*: requires practices that are intended to ensure individuals are safe; in a humane environment; and are protected from harm from unnecessary or improperly applied restraint or from abuse, neglect, exploitation, serious injury, and other serious incidents.
- (2) *Section I, At-Risk Individuals*: requires a risk screening, assessment, and management system to identify individuals whose health or well-being is at risk and to take preventive interventions to minimize the conditions of risk.

- (3) *Section O, Minimum Common Elements of Physical and Nutritional Management*: contains intensive services for individuals who cannot feed themselves, who require positioning assistance, who have difficulty swallowing, or who are at risk of choking or aspiration. Aspiration pneumonia, in particular, is a primary cause of death associated with persons with developmental disabilities that is considered to be often preventable.

Staff Recruitment and Retention

SSLCs face significant challenges in recruiting and retaining physicians, psychiatrists, therapists, dietitians, and direct care staff. In FY 2012, the average fill rate of budgeted full time equivalents (FTEs) was 80% for physicians; 60% for psychiatrists and therapists; and 78% for dietitians. The turnover rate for direct care staff of all types exceeds 40% annually.¹² Since continuity of care is a critical factor in meeting the demands of the settlement agreement and intermediate care facilities standards, it is critical to achieve consistent direct care staff fill rates.

SSLCs are frequently in the position of having to acquire clinical and professional staff through contracts with temporary staffing agencies or through direct professional services contracts when vacancies exist. These contracted services are significantly more expensive than the cost of filled positions because contracted rates include the cost of administering the contract and profit to the staffing agencies. Additionally, while contracting clinical professionals can be an immediate answer to providing necessary services, this does not ensure and may even impair the ability to ensure the critical component of continuity of care for residents in the SSLCs.¹³

Because of declining populations at SSLCs, DADS should attempt to address much of its staffing needs within current funding levels, assuming that the projected census levels are realized. DADS has also requested funding for certain clinical positions as part of its FY 2014-15 Legislative Appropriations Request (LAR).¹⁴

Leveraging Technology

DADS should consider leveraging improved health information technology (IT) in SSLCs, specifically by using electronic life records and relying on telemedicine where possible.

- (1) *Electronic Life Records*: An electronic life record (wireless system) would assist with maintaining documentation in the manner called for by the settlement agreement. An electronic life record differs from an electronic medical record because the records contain a significantly broader and more complex set of data and information, much of which is not specifically related to provision of health care services. For this reason, the term “electronic life record” is used to clearly differentiate the system requirements for this record as compared to a traditional “electronic health record” that may be used in either an acute or long-term healthcare setting.

The current paper system does not allow an integrated process of care due to the multiple locations and staff that need to enter information by hand into the record. An electronic life record would allow staff to record information as it happens and would make the information available to all staff that needed the information. The electronic life record would result in a more efficient use of staff resources and decrease the amount of human errors.¹⁵

Again, DADS should use existing resources due to declining populations to the extent possible to improve information technology. DADS has requested \$19.4 million for electronic life records as an exceptional item in its FY 2014-15 LAR.¹⁶

- (2) *Telemedicine*: Telemedicine is not currently utilized in SSLCs. DADS carried out a telemedicine pilot program at the Brenham and Richmond SSLCs approximately five years ago, with noted success for some limited functions and services. Although telemedicine cannot substitute all on-site, face-to-face care, DADS should explore beneficial outcomes and potential efficiencies and cost savings from the use of telemedicine in SSLCs within the bounds of the settlement agreement.¹⁷

Section III. Conclusion

Although there are encouraging signs of progress within our SSLC system, there is still a considerable amount of work to be done to ensure the state reaches substantial compliance with the DOJ settlement agreement in a timely manner. DADS must have a well thought out plan, including performance measures and deadlines, to achieve compliance in each targeted improvement area and to ensure a protective and quality environment for the SSLC community.

Section IV. Recommendations

- 1. DADS should identify a plan of action to achieve substantial compliance and present this plan and any progress made to the Legislature in an annual report.**
- 2. DADS should provide a data analysis on a quarterly basis to the Legislature outlining the progress at each SSLC in each targeted improvement area.**
- 3. DADS should test new ideas and best practices through a pilot process to potentially expand statewide.**
- 4. DADS should identify the most critical issues facing SSLCs and included in the settlement agreement and direct time and resources accordingly.**

¹Information provided by Department of Aging and Disability Services staff via email, October 10, 2012.

² SSLC map available at <http://www.dads.state.tx.us/services/SSLC/index.html> (Last accessed November 20, 2012).

³ See <http://www.senate.state.tx.us/75r/senate/members/dist12/pr09/p052109a.htm> (Last accessed November 20, 2012).

⁴ Chris Traylor, Department of Aging and Disability Services, *Testimony before the Senate Committee on Health and Human Services*, Austin, Texas, July 31, 2012, p. 5.

⁵ See <http://www.senate.state.tx.us/75r/senate/members/dist12/pr09/p061209a.htm> (Last accessed November 20, 2012).

⁶ Information provided by Department of Aging and Disability Services staff via email, September 20, 2012.

⁷ See 2009-09, 2010-11, and 2012-13 General Appropriations Acts available at <http://www.lbb.state.tx.us/StateBudgetsGAA.aspx> (Last accessed November 20, 2012).

⁸ *Supra* note 4 at p. 3-4.

⁹ *Id.* at p. 7.

¹⁰ *Id.*

¹¹ Information provided by Department of Aging and Disability Services staff via email, November 14, 2012.

¹² Information provided by Department of Aging and Disability Services staff via email, November 12, 2012.

¹³ *Id.*

¹⁴ Department of Aging and Disability Services' Legislative Appropriations Request for Fiscal Years 2014-15 available at <http://cfoweb.dads.state.tx.us/lar/default.asp> (Last accessed November 20, 2012).

¹⁵ *Supra* note 12.

¹⁶ *Supra* note 14.

¹⁷ Information provided by Department of Aging and Disability Services staff via email, August 17, 2012.

Appendix 1

DOJ Settlement Agreement Requirements

Items with a dark gray background are not counted in the 161 requirements. Light green and white backgrounds differentiate Sections of the Settlement Agreement.

§	Requirement
C1	No prone restraints. Restraint use only if immediate and serious risk of harm; after a graduated range of less restrictive measures; reasons other than punishment
C2	Terminate restraint as soon as individual is no longer a danger to self or others
C3	Policies governing restraints. Restraint must be least restrictive intervention. All staff must have competency-based training on restraint technique
C4	Limit use of all restraints, other than medical, to crisis interventions; strategies to minimize the need for medical restraints included in ISP
C5	Restraint monitoring: Face-to-face assessment (15 min) monitor and document vital signs (30 min)
C6	Restraint procedure & documentation: check for injury, opportunity for exercise, eat near meals, drink fluids, use toilet/bed pan.
C7	Longitudinal assessment of restraint use for each individual (≥ 3 restraints in rolling 30 day period)
C7a	Review adaptive skills and biological, medical and psychosocial factors
C7b	Review contributing environmental factors
C7c	Review or perform structural assessments of behavior provoking restraints
C7d	Review functional assessment of behavior provoking restraints
C7e	Develop and implement PBSP based on individual's strengths
C7f	Individual's treatment plan is implemented w/ high degree of treatment integrity
C7g	As necessary, assess and revise PBSP
C8	Within 3 business days each facility will review the use each use of restraint
D1	Policies and procedures: no tolerance of ANE; and staff are required to report

DOJ Settlement Agreement Requirements

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§	Requirement
D2	Implement Incident management policies and procedures:
D2a	Immediately report serious incidents and serious injurious
D2b	Take immediate action to protect individuals
D2c	Competency based training on Signs of ANE
D2d	Notification of obligation to report ANE
D2e	Mechanisms to educate and support individuals, LARs and correspondents to identify and report ANE
D2f	Postings on rights including information for reporting violations of rights
D2g	Procedures for referring ANE to law enforcement
D2h	Reporters not subject to retaliation
D2i	Audits to determine that significant injuries are reported
D3	Timely and thorough investigation of ANE, death, theft, serious injury and other serious incidents
D3a	Investigators are qualified; trained in working with people with DD; outside the direct line of supervision
D3b	Cooperation with outside entities conducting investigations
D3c	Coordinate investigations with law enforcement
D3d	Safeguard evidence
D3e	Start investigations within 24 hours and be completed within 10 calendar days

DOJ Settlement Agreement Requirements

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§	Requirement
D3f	Investigative reports provide clear basis for its conclusion
D3g	Written reports are reviewed by supervisory staff
D3h	Facility also prepares a written report for each unusual incident
D3i	Corrections to prevent a reoccurrence are implemented promptly and thoroughly; such actions are tracked and documented
D3j	Investigation records are maintained to allow easy access
D4	Tracking and trending of unusual incidents and investigation results
D5	Background investigation of all staff or volunteers who work with individuals more than 5 times per year
E1	Comprehensive QA procedures include: Track data with sufficient particularity to identify trends
E2	Analyze date and, when needed, develop corrective action plans
E3	Disseminate corrective action plans to all responsible entities
E4	Monitor and document corrective action plans to ensure implementation
E5	Modify corrective action plans, as necessary, to ensure effectiveness
F1	Interdisciplinary teams for each individual:
F1a	Team facilitated by one person; members participate in assessing, developing, monitoring, and revising
F1b	Team includes required members
F1c	Conduct comprehensive assessments, routinely and in response to changes; of sufficient quality

DOJ Settlement Agreement Requirements

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§	Requirement
F1d	Assessment results are used to develop, implement, and revise ISP
F1e	Develop ISP in accordance with ADA and Olmstead
F2	Policies and procedures that provide for the development of integrated ISPs
F2a	ISP developed and implemented for each individual
F2a1	ISP addresses preferences and strengths, prioritized needs, explains barriers, and encourages community participation
F2a2	Specifies measurable goals and objectives; overcome identified barriers to living in most integrated setting
F2a3	Integrates all protections, services and supports
F2a4	Identifies methods for implementation, time frames and responsible staff
F2a5	Provides practical and functional services that effectively address needs
F2a6	Identifies data to be collected; frequency of collection; person responsible for collection; person responsible for review
F2b	Coordinated all goals, objectives, anticipated outcomes, services, supports and treatments in ISP
F2c	ISP is assessable and comprehensible to staff responsible for implementing
F2d	Assess progress monthly and take necessary corrective action
F2e	Competency-based staff training on ISP development and implementation processes
F2f	ISP prepared within 30 days of admission and revised annually; put into effect within 30 days of preparation
F2g	QA processes – ensure ISP developed & implemented consistent with Provision F

DOJ Settlement Agreement Requirements

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§	Requirement
G1	Provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy)
G2	Appropriate clinician review recommendation for non-facility clinicians
H1	Assessments and evaluations done regularly and in response to change in status
H2	Diagnoses shall clinically fit the corresponding assessments or evaluations and be consistent with DSM and ISCDRHP
H3	Treatments and interventions are timely and clinically appropriate based upon assessments and diagnoses
H4	Clinical indicators of the efficacy of treatments & interventions are determined in a clinically justified manner
H5	System developed and maintained to effectively monitor health status of individuals
H6	Treatments and interventions modified in response to clinical indicators
H7	Integrated clinical services policies, procedures and guidelines to implement Provision H
I1	Regular risk screening, assessment and a management system to identified individuals whose health or well-being is at risk
I2	Interdisciplinary assessment of services and supports for at-risk individuals (5 working days)
I3	Implement a plan to minimize risk within 14 days; integrated into ISP
J1	Provide psychiatric services only by qualified professionals
J2	Psychotropic meds only after evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist
J3	No psychotropic meds as substitute for treatment, in absence of psychiatric diagnosis; for convenience of staff or as punishment
J4	Pre-treatment sedation for medical and dental care: strategies to minimize or eliminate; coordinate with other supports and services

DOJ Settlement Agreement Requirements

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§	Requirement
J5	Sufficient board-certified or board-eligible psychiatrists to assure provision of required services
J6	Procedures for psychiatric assessment, diagnosis and case formulation (Appendix B)
J7	Use Reiss Screen for Maladaptive Behaviors to screen for possible psychiatric disorder; all identified individuals receive a comprehensive psychiatric assessment and diagnosis
J8	Integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.
J9	Least intrusive and most positive interventions to treat behavioral or psychiatric condition
J10	Comprehensive assessment prior to non-emergency administration of psychotropic medications
J11	Facility-level review system for monthly monitoring of prescription of 2 or more psychotropic medications
J12	System for monitoring, detecting, reporting and responding to side effects of psychotropic medications; at least quarterly (such as MOSES/DISCUS)
J13	Psychotropic medication treatment plan includes: clinically justifiable diagnosis or behavioral-pharmacological hypotheses; therapeutic effect timeline. Treatment to be monitored no less than quarterly
J14	Informed consent must be obtained prior to administering psychotropic medications or other restrictive procedures
J15	Neurologist and psychiatrist coordinate use of medications through the IDT process when they are prescribed to treat both seizures and a mental health disorder
K1	Facility provides individualized services and comprehensive programs by professionals with a master's degree for all persons requiring PBSPs
K2	Qualified director of psychology
K3	Establish a peer-based system to review the quality of PBSPs
K4	Develop and implement standard procedures for data collection for PBSPs
K5	Standard psychological assessment procedures that identify medical, psychiatric, environmental or other reasons for target behaviors and for other psychological needs that may require intervention.

DOJ Settlement Agreement Requirements

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§	Requirement
K6	Psychological assessments based on current, accurate and complete clinical and behavioral data.
K7	All psychological assessments completed pursuant to the facility's standard psychological assessment procedures
K8	Assure individuals needing psychological services other than PBSPs receive such services
K9	Develop PBSP, obtain necessary consents and approvals and implement.
K10	Documentation related to PBSPs must be organized and maintained so that progress can be measured to determine efficacy of treatment.
K11	PBSPs written to allow understanding for implementation by direct care staff
K12	Provision of competency-based training for all direct care staff and supervisors for PBSPs
K13	Maintain an average ratio of psychology professionals of 1:30 and psychology assistants of 1:60.
L1	All individuals receive routine, preventive and emergency medical care consistent with current, generally accepted professional standards.
L2	Establish and maintain a medical review system that consists of non-Facility physician case review and assistance
L3	Medical quality improvement process to collect data relating to the quality of medical services; assess data for trends; initiate outcome-oriented inquiries, identify and initiate corrective actions and monitoring to assure remedies are achieved.
L4	Policies and procedures for provision of medical care consistent with current, generally accepted professional standards of care
M1	Nurses shall document nursing assessments, identify health care problems, notify physician of health care problems, monitor, intervene, and keep appropriate records of individuals' health care status sufficient to readily identify changes in status.
M2	Update nursing assessments of nursing care needs for each individual quarterly or more often as indicated by the individual's health status.
M3	Develop nursing interventions annually to address each individual's health care needs.
M4	Develop and implement a nursing assessment and reporting protocol to address health status of individuals served.

DOJ Settlement Agreement Requirements

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§	Requirement
M5	Develop and implement a system of assessing and documenting clinical indicators of risk for each individual
M6	Develop and implement nursing procedures for administration of medications in accordance with current, generally accepted professional standards of care and which provide necessary supervision and training to minimize medication errors.
N1	Pharmacist medication regimen reviews at prescription of a new medication and as otherwise clinically indicated
N2	Quarterly comprehensive drug regimen reviews
N3	Collaboration between prescribing medical practitioners and pharmacists for monitoring of use of "stat" medications and chemical restraints
N4	Treating medical practitioners shall consider pharmacist recommendations and document any recommendations not followed noting clinical rationale
N5	Quarterly tardive dyskinesia monitoring using MOSES or DISCUS
N6	Significant or unexpected adverse drug reactions
N7	Regular drug utilization evaluations in accordance with current, generally accepted professional standards of care
N8	Regular documentation, reporting, data analysis and follow- up remedial action regarding actual and potential medication variances.
O1	PNMPs for all appropriate individuals and a PNM Team.
O2	Physical and nutritional interventions for each person with challenges in feeding positions and/or swallowing or with a history of aspiration
O3	Maintain and implement adequate mealtime, oral hygiene and oral medication administration plans for individuals having physical or nutritional management problems.
O4	Staff engage in mealtime practices that do not pose risk of harm to any individual
O5	Competency-based training for all staff working with persons with PNMPs
O6	Monitor implementation of mealtime and positioning plans to ensure staff demonstrates competencies to safely and appropriately implement such plans.

DOJ Settlement Agreement Requirements

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§	Requirement
O7	Develop and implement a system to monitor progress of individuals with PNMPs
O8	Evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary.
P1	OT & PT screenings of each individual at the facility and comprehensive integrated OT & PT assessments.
P2	Plan to address recommendations from comprehensive OT & PT assessments
P3	Staff training related to OT & PT screenings, assessments and program plans
P4	Systems to monitor and address screenings, evaluations, program plans and plan implementation for OT & PT services
Q1	Adequate and timely routine and emergency dental care and treatment consistent with current, generally accepted ADA standards.
Q2	Policies and procedures regarding comprehensive, timely provision of assessments and dental services.
R1	Adequate # of speech language pathologists or other professionals to conduct assessments, develop and implement programs, provide staff training and monitor the implementation of programs.
R2	Develop and implement a screening and assessment process to identify who could benefit from augmentative communication systems, including systems involving behavioral supports or interventions.
R3	Specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.
R4	Monitoring system to ensure that the communication provisions of the ISP address communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them.
S1	Provide adequate habilitation services including individualized training, education, and skill acquisition programs developed by IDTs to promote growth, development and independence of all individuals.
S2	Annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration in the areas of living, working and engaging in leisure activities.
S3	Use information from assessments and review processes to develop, integrate and revise programs of training, education, and skill acquisition to address each individual's needs.
S3a	Interventions that (1) address needs for services and (2) are practical and functional

DOJ Settlement Agreement Requirements

Items with a **dark gray** background are not counted in the 161 requirements. Light green and white backgrounds differentiate Sections of the Settlement Agreement.

§	Requirement
S3b	Training opportunities in the community
T1	Planning for Movement Transition and Discharge
T1a	State shall take action to encourage and assist movement to the most integrated setting
T1b	Facility shall review, revise, or develop, and implement policies, procedures and practices related to transition and discharges
T1b1	Living in the most integrated setting possible – ISPs include all required steps to accomplish.
T1b2	Education for individuals and their LARs regarding available community placements to make informed choices
T1b3	Assess at least 50% of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge.
T1c	Develop and implement a community living discharge plan and coordinate with community provider staff.
T1c1	Implement and coordinate community discharge plan with provider staff
T1c2	Specify staff responsible and timeframes
T1c3	Review with individual and LAR.
T1d	Comprehensive assessment of each needs for each individual leaving the facility for a community setting
T1e	Verify supports determined by professional judgment are essential to the individual's health and safety and are in place at the transitioning individual's new home before departure from the facility.
T1f	Quality assurance processes to ensure community living discharge plans are developed, and implemented by the facility prior the individual's departure
T1g	Gather and analyze information related to obstacles to successful community placement and report annually on identification and remediation efforts.
T1h	Each facility must develop and issue to the Monitor and to DOJ a Community Placement Report

DOJ Settlement Agreement Requirements

Items with a **dark gray** background are not counted in the 161 requirements. Light green and white backgrounds differentiate Sections of the Settlement Agreement.

§	Requirement
T2	Serving persons who have moved from the facility to more integrated settings appropriate to their needs
T2a	Conduct post-move monitoring visits within each of three intervals of 7, 45 and 90 days respectively following an individual's move to the community
T2b	Monitor may review and participate in post-move monitoring visits
T3	Non-applicability of procedures at Section T for individuals admitted for court-ordered evaluations.
T4	Compliance with all CMS-required discharge planning procedures for persons moving out of state; persons discharged from emergency admission; discharged after order of protective custody; individuals receiving respite services for up to 60 days; for individuals determined not to be eligible for admission; individuals discharged pursuant to court order vacating a commitment order.
U1	Facility shall maintain and update semi-annually a prioritized list of individuals lacking both functional capacity to render a decision regarding health or welfare and an LAR to render such decision
U2	Make reasonable efforts to obtain LAR for any individual lacking both functional capacity to render a decision regarding health or welfare and an LAR to render such decision
V1	Maintain a unified record for each individual consistent with guidelines in Appendix D
V2	Develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this agreement.
V3	Implement additional QA procedures to ensure a unified record for each individual consistent with guidelines in Appendix D [cross-reference with V1 above]
V4	Routinely use unified records in making care, medical treatment and training decisions.

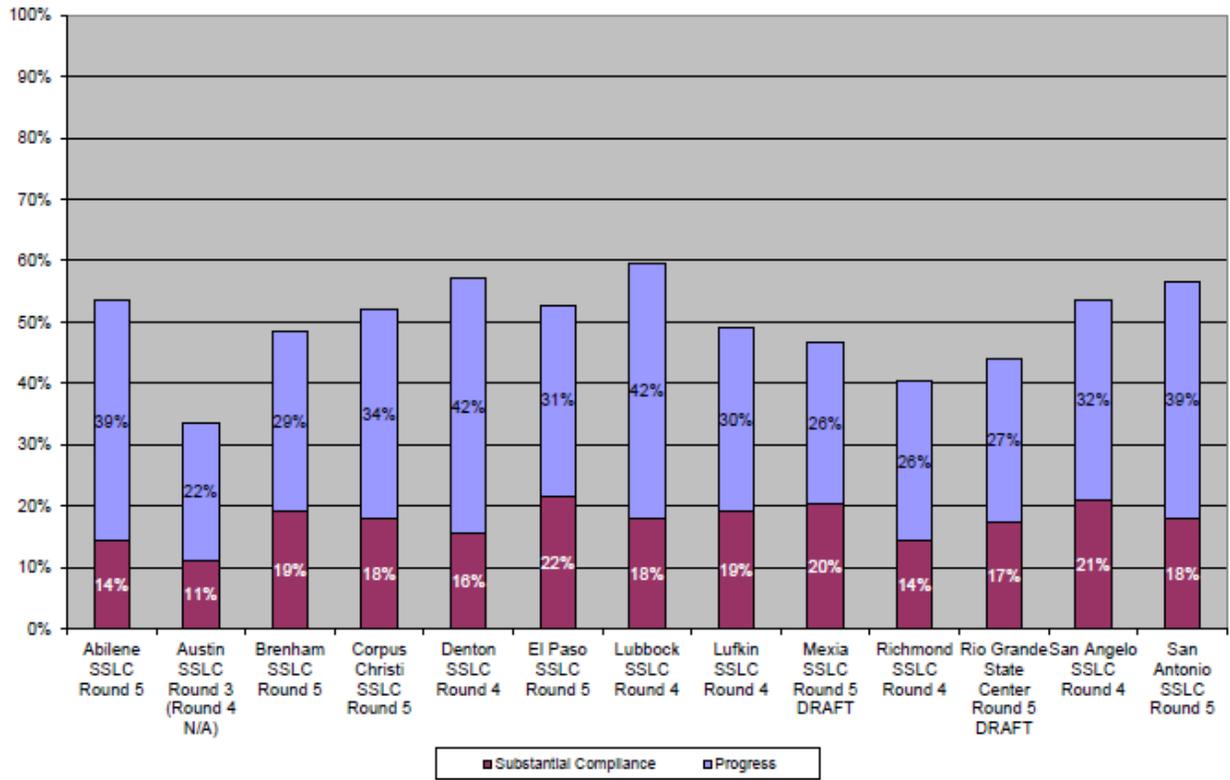
Appendix 2

Compliance Determinations for the DOJ Settlement Agreement As Of 11/9/2012

Substantial Compliance																												
Section	Number of Sub-Elements	Arlene SCLC		Austin SCLC		Breham SCLC		Corpus Christi SCLC		Denton SCLC		El Paso SCLC		Lubbock SCLC		Lufkin SCLC		Meza SCLC		Richmond SCLC		Rio Grande Center		San Angelo SCLC		San Antonio SCLC		
		Substantial Compliance	Percentage																									
Section C	14	0%	0%	0%	4	29%	0%	1	7%	3	21%	2	14%	3	21%	1	7%	1	7%	1	7%	3	21%	1	7%	3	21%	
Section D	22	18	73%	11	50%	10	45%	10	45%	13	59%	14	64%	12	55%	14	64%	13	60%	13	60%	15	68%	14	64%	14	64%	
Section E	5	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1	20%	0%	0%	0%	0%	0%	0%	0%	0%	1	20%	0%	0%	
Section F	17	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Section G	2	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Section H	7	0%	0%	0%	0%	0%	1	14%	0%	0%	0%	0%	1	14%	0%	0%	0%	0%	1	14%	0%	0%	1	14%	0%	0%	1	14%
Section I	3	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Section J	10	1	10%	3	30%	2	20%	8	80%	5	50%	3	30%	4	40%	2	20%	2	20%	0%	0%	4	40%	1	10%	3	30%	
Section K	13	1	8%	1	8%	1	8%	1	8%	2	15%	2	15%	1	8%	2	15%	3	23%	1	8%	1	8%	3	23%	1	8%	
Section L	4	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Section M	6	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1	17%	0%	0%	0%	0%	0%	0%	0%	0%	
Section N	8	2	25%	0%	0%	5	63%	2	25%	3	38%	3	38%	4	50%	0%	0%	3	38%	4	50%	2	25%	0%	0%	3	38%	
Section O	8	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1	13%	0%	0%	
Section P	4	0%	0%	0%	1	25%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Section Q	2	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Section R	4	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Section S	4	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Section T	17	3	18%	3	18%	3	18%	4	24%	1	6%	3	18%	4	24%	3	18%	6	35%	2	12%	2	12%	7	41%	2	12%	
Section U	4	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Section V	4	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
	161	23	14%	18	11%	31	19%	29	18%	25	16%	35	22%	28	18%	31	19%	33	20%	23	14%	28	17%	34	21%	29	18%	

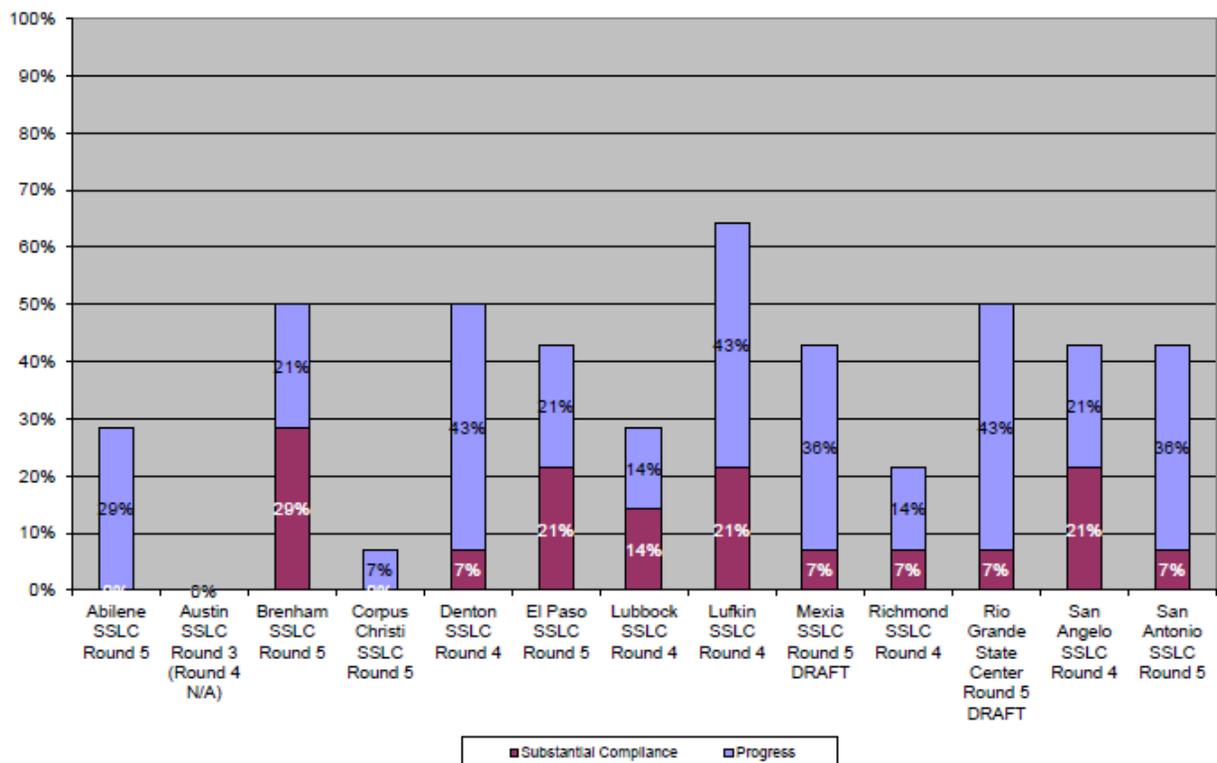
Progress Noted																												
Section	Number of Sub-Elements	Arlene SCLC		Austin SCLC		Breham SCLC		Corpus Christi SCLC		Denton SCLC		El Paso SCLC		Lubbock SCLC		Lufkin SCLC		Meza SCLC		Richmond SCLC		Rio Grande Center		San Angelo SCLC		San Antonio SCLC		
		Progress	Percentage	Progress	Percentage	Progress	Percentage	Progress	Percentage	Progress	Percentage	Progress	Percentage	Progress	Percentage	Progress	Percentage	Progress	Percentage	Progress	Percentage	Progress	Percentage	Progress	Percentage	Progress	Percentage	
Section C	14	4	29%	0%	3	21%	1	7%	8	43%	3	21%	2	14%	6	43%	5	36%	2	14%	6	43%	3	21%	5	36%		
Section D	22	3	14%	1	5%	3	14%	1	5%	1	5%	5	23%	1	5%	1	5%	0%	0%	0%	0%	2	9%	2	9%	2	9%	
Section E	5	2	40%	1	20%	1	20%	1	20%	3	60%	4	80%	3	60%	2	40%	1	20%	2	40%	2	40%	4	80%	5	100%	
Section F	17	11	65%	4	24%	3	18%	8	47%	3	18%	5	29%	7	41%	5	29%	5	29%	1	6%	1	6%	5	29%	4	24%	
Section G	2	0%	0%	0%	1	50%	1	50%	2	100%	1	50%	2	100%	1	50%	1	50%	2	100%	1	50%	1	50%	1	50%	2	100%
Section H	7	2	29%	1	14%	5	71%	4	57%	5	71%	3	43%	4	57%	0%	0%	1	14%	3	43%	3	43%	2	29%	3	43%	
Section I	3	1	33%	1	33%	2	67%	1	33%	2	67%	1	33%	2	67%	1	33%	0%	0%	1	33%	0%	0%	1	33%	2	67%	
Section J	10	8	80%	6	60%	10	100%	7	70%	7	70%	3	30%	10	100%	4	40%	4	40%	4	40%	5	50%	3	30%	5	50%	
Section K	13	8	62%	2	15%	1	8%	3	23%	8	62%	5	38%	10	77%	7	54%	5	38%	5	38%	8	62%	6	46%	8	62%	
Section L	4	1	25%	1	25%	0%	0%	2	50%	3	75%	1	25%	3	75%	1	25%	0%	0%	3	75%	1	25%	0%	0%	2	50%	
Section M	6	5	83%	0%	0%	5	83%	0%	0%	3	50%	2	33%	2	33%	2	33%	4	67%	5	83%	2	33%	0%	0%	5	83%	
Section N	8	5	63%	2	25%	2	25%	0%	0%	3	38%	1	13%	2	25%	1	13%	2	25%	1	13%	3	38%	2	25%	1	13%	
Section O	8	0%	0%	1	13%	1	13%	0%	0%	5	63%	3	38%	4	50%	2	25%	2	25%	1	13%	1	13%	3	38%	3	38%	
Section P	4	1	25%	1	25%	1	25%	0%	0%	2	50%	1	25%	1	25%	0%	0%	1	25%	1	25%	1	25%	1	25%	2	50%	
Section Q	2	2	100%	2	100%	0%	0%	2	100%	0%	0%	0%	0%	0%	0%	1	50%	0%	0%	0%	0%	0%	0%	1	50%	0%	0%	
Section R	4	2	50%	2	50%	1	25%	0%	0%	2	50%	1	25%	1	25%	2	50%	0%	0%	1	25%	0%	0%	0%	0%	1	25%	
Section S	4	1	25%	0%	0%	0%	0%	3	75%	1	25%	3	75%	1	25%	4	100%	2	50%	0%	0%	0%	0%	3	75%	3	75%	
Section T	17	8	47%	5	29%	6	35%	7	41%	5	29%	7	41%	3	18%	4	24%	4	24%	8	47%	7	41%	8	47%	4	24%	
Section U	2	2	100%	2	100%	0%	0%	2	100%	2	100%	2	100%	1	50%	1	50%	2	100%	0%	0%	2	100%	2	100%	2	100%	
Section V	4	4	100%	4	100%	3	75%	4	100%	3	75%	3	75%	4	100%	3	75%	3	75%	3	75%	4	100%	3	75%	3	75%	
	161	63	39%	36	22%	47	29%	55	34%	67	42%	50	31%	67	42%	48	30%	42	26%	42	26%	45	28%	52	32%	62	39%	

State Supported Living Center Compliance Summary
Department of Justice Settlement Agreement
Percentage of Requirements Showing Progress or Substantial Compliance
Total Number of Requirements = 161
As of November 9, 2012



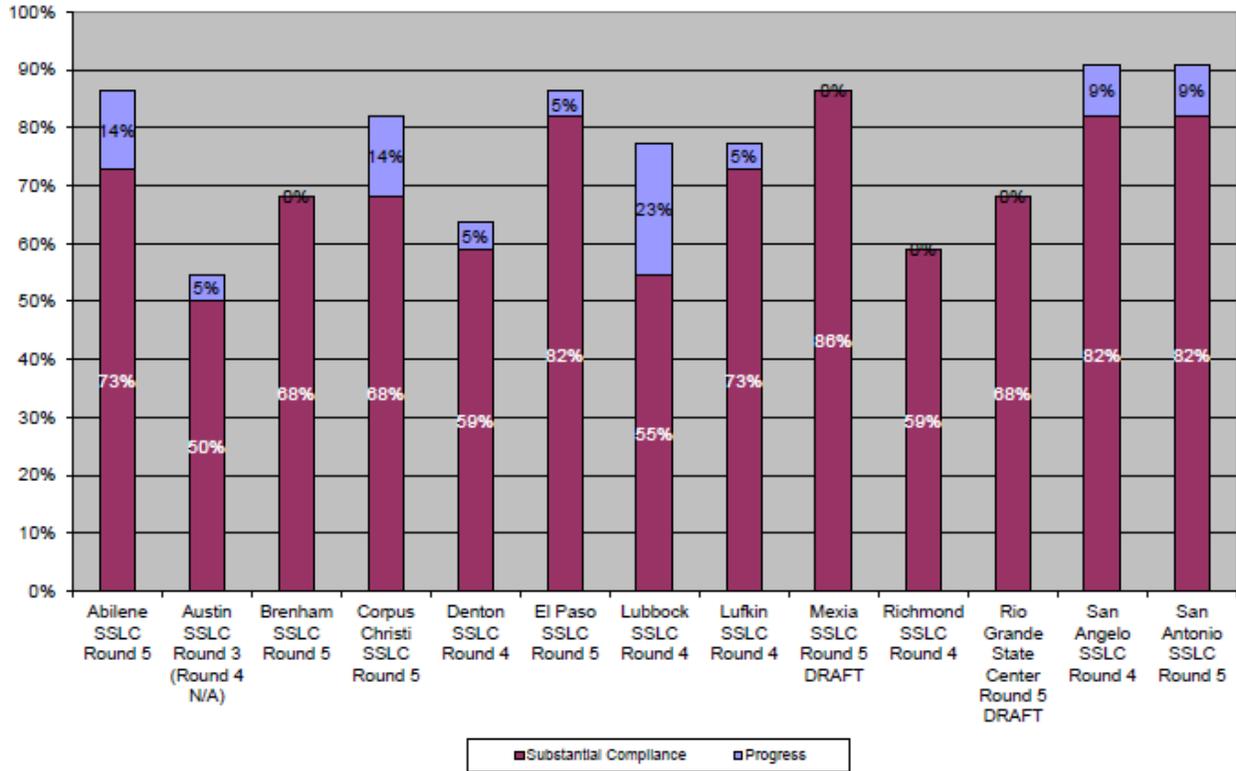
**State Supported Living Centers
Department of Justice Settlement Agreement
Section C - Restraint Usage
14 Items in this Section**

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



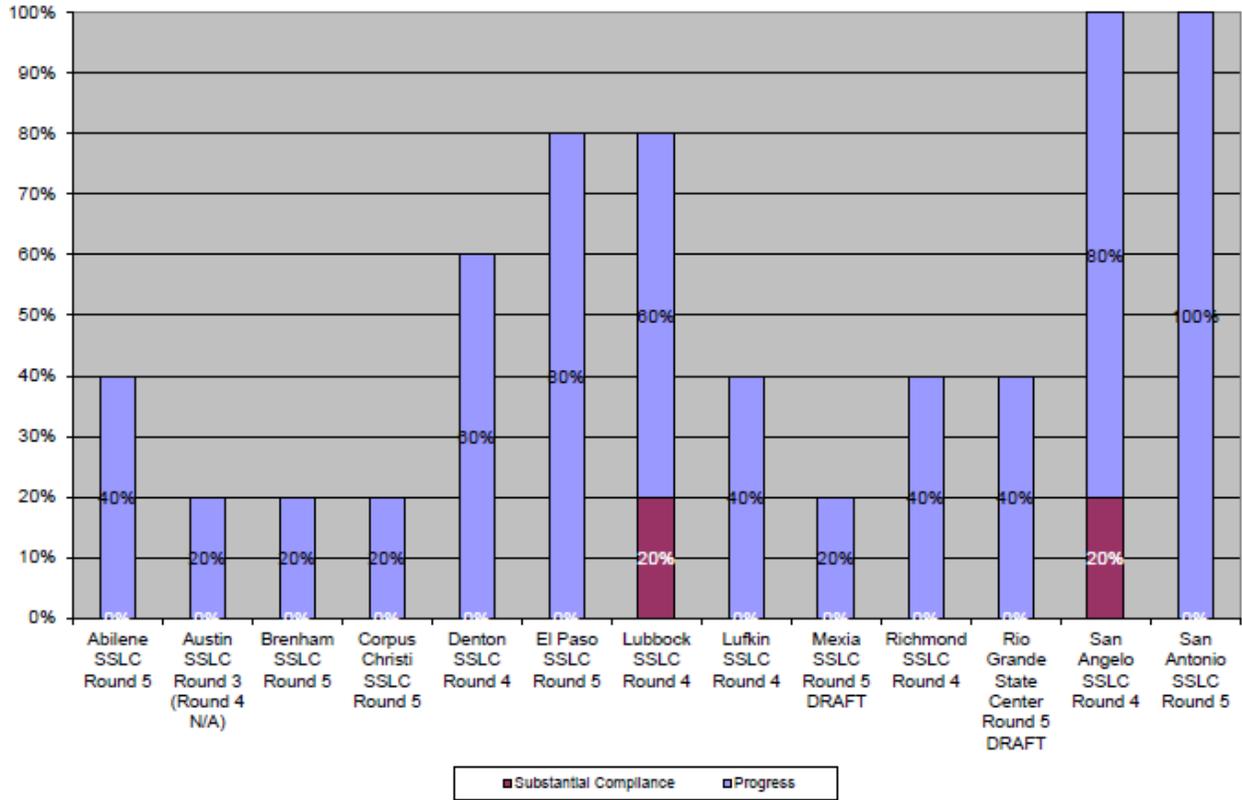
State Supported Living Centers
Department of Justice Settlement Agreement
Section D - Protection from Harm
22 Items in this Section

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



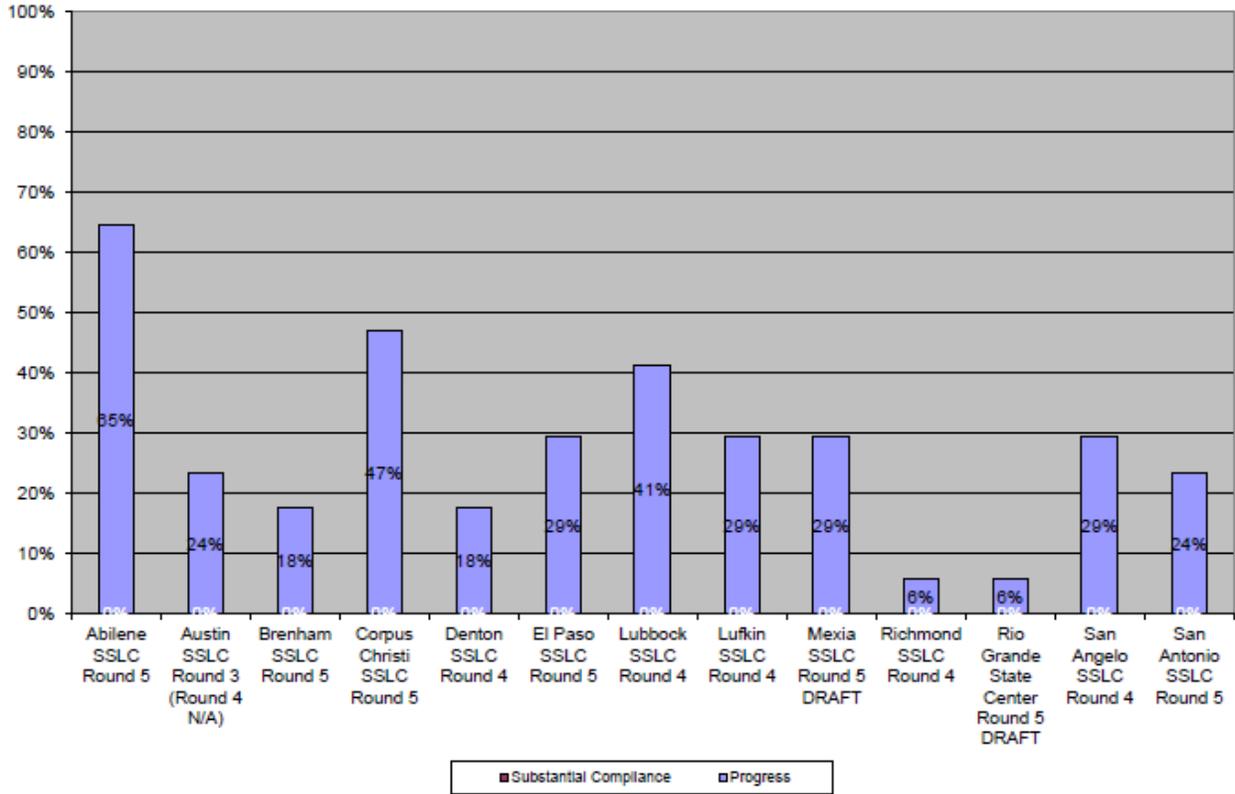
**State Supported Living Centers
 Department of Justice Settlement Agreement
 Section E - Quality Assurance
 5 Items in this Section**

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



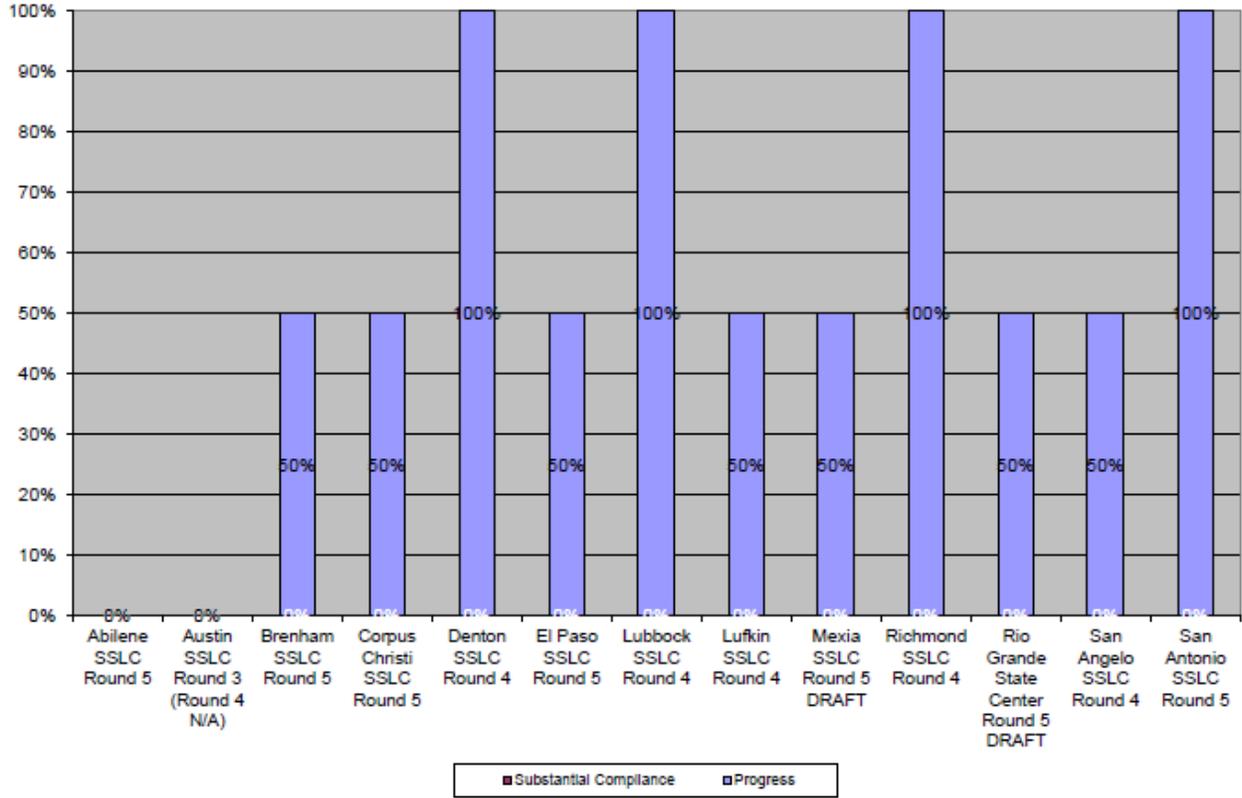
**State Supported Living Centers
 Department of Justice Settlement Agreement
 Section F - IDTs & ISPs
 17 Items in this Section**

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



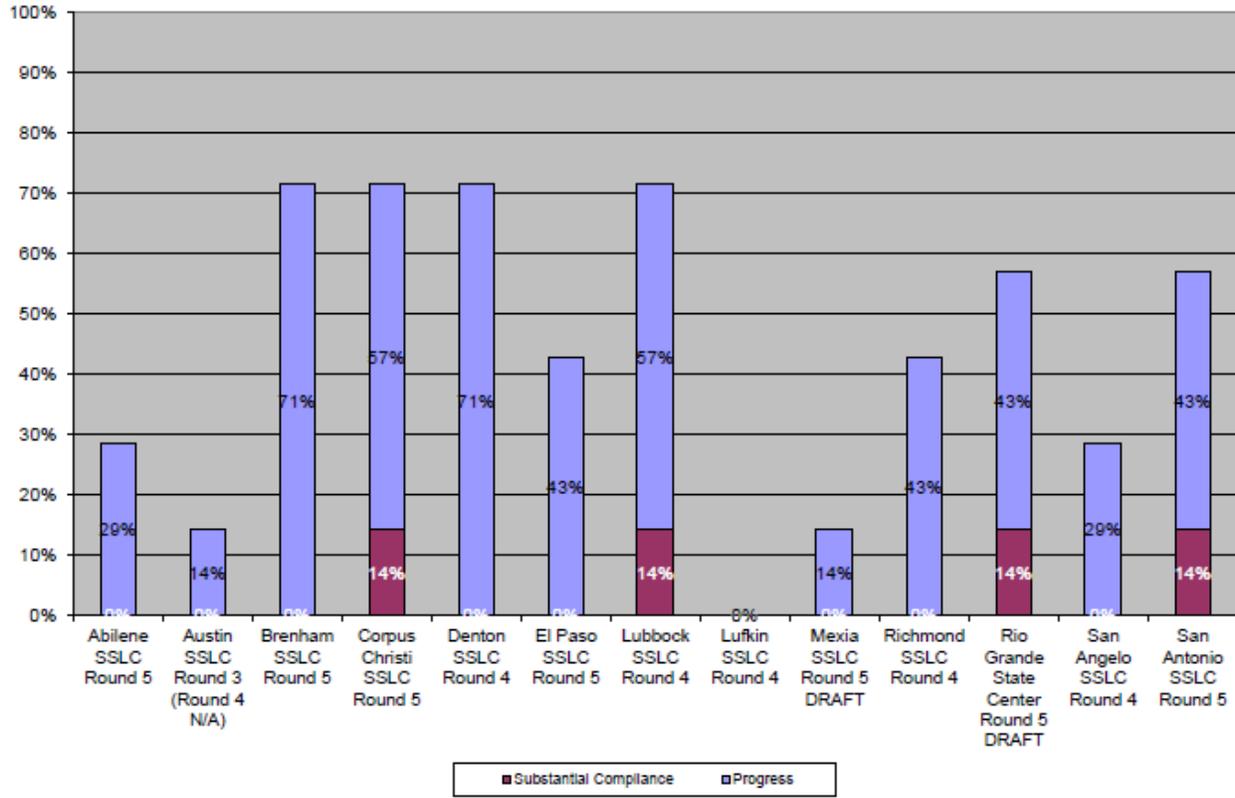
**State Supported Living Centers
 Department of Justice Settlement Agreement
 Section G-Integrated Clinical Services
 2 Items in this Section**

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



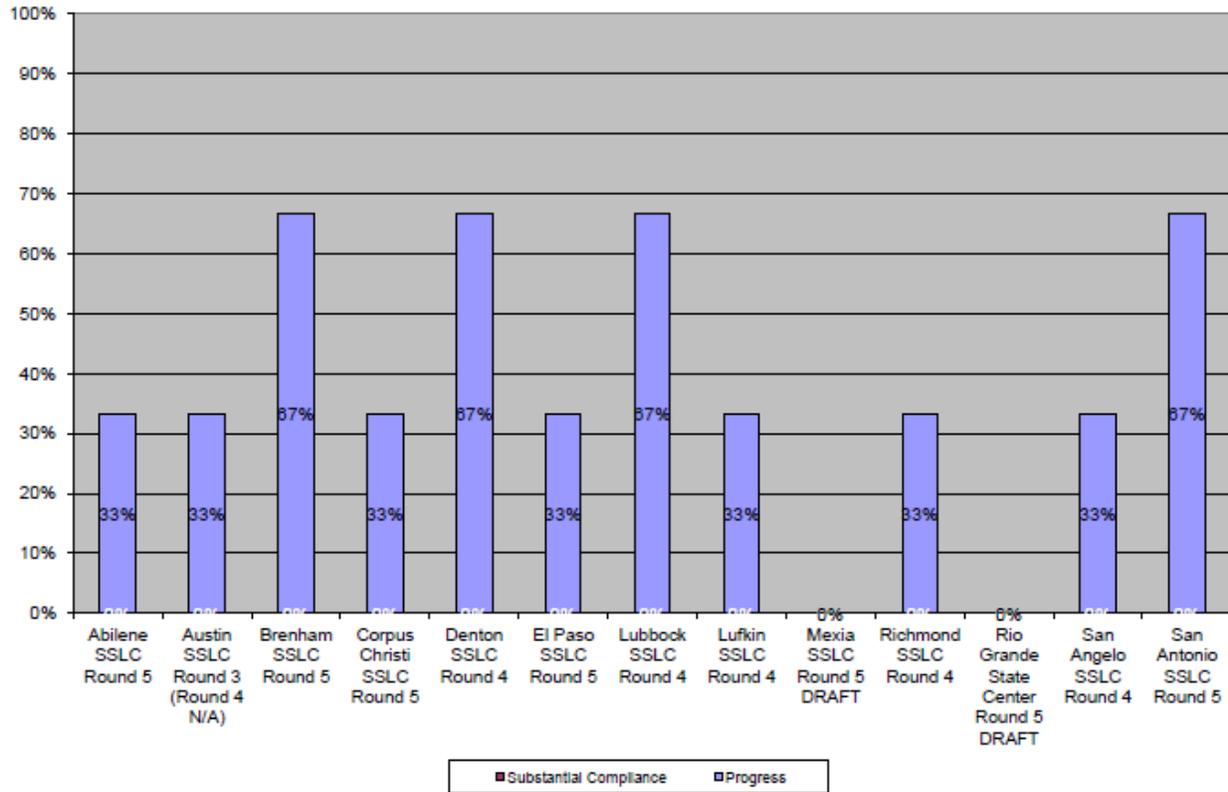
**State Supported Living Centers
 Department of Justice Settlement Agreement
 Section H-Elements of Clinical Services
 7 Items in this Section**

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



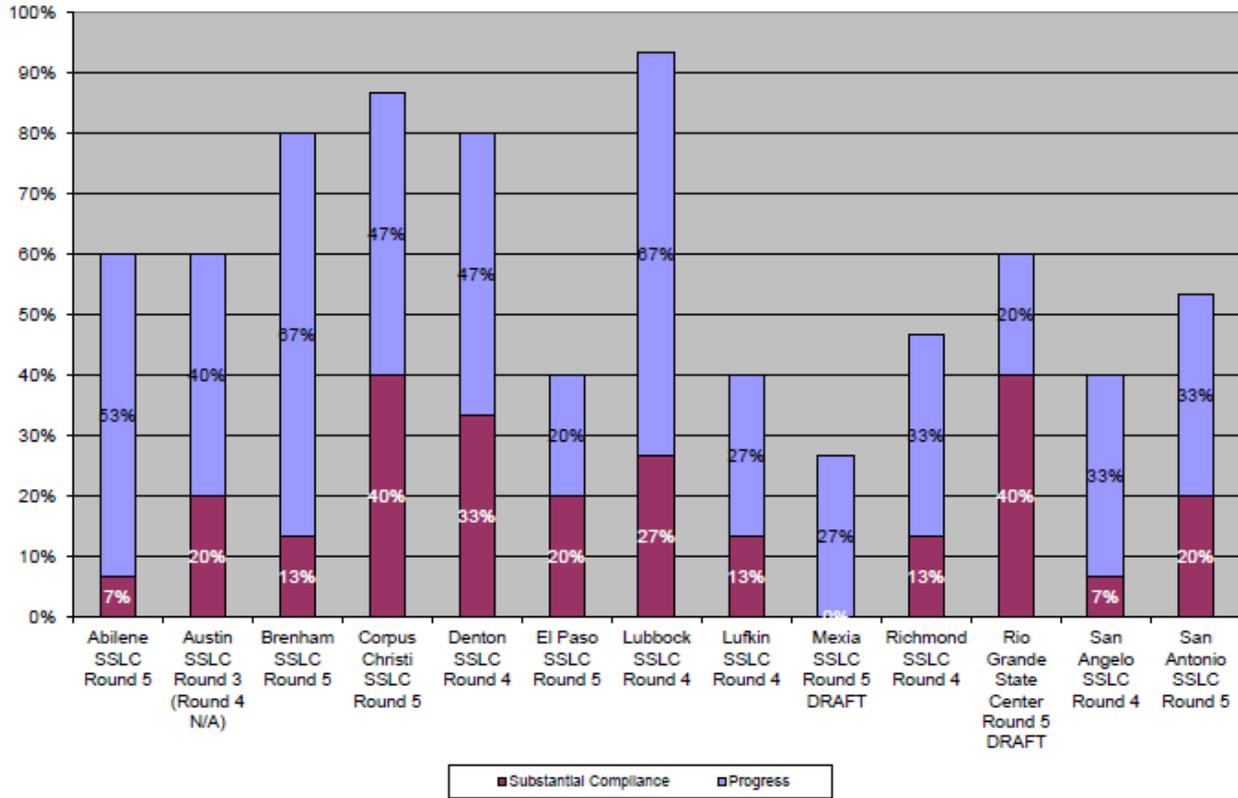
**State Supported Living Centers
 Department of Justice Settlement Agreement
 Section I - At Risk
 3 Items in this Section**

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



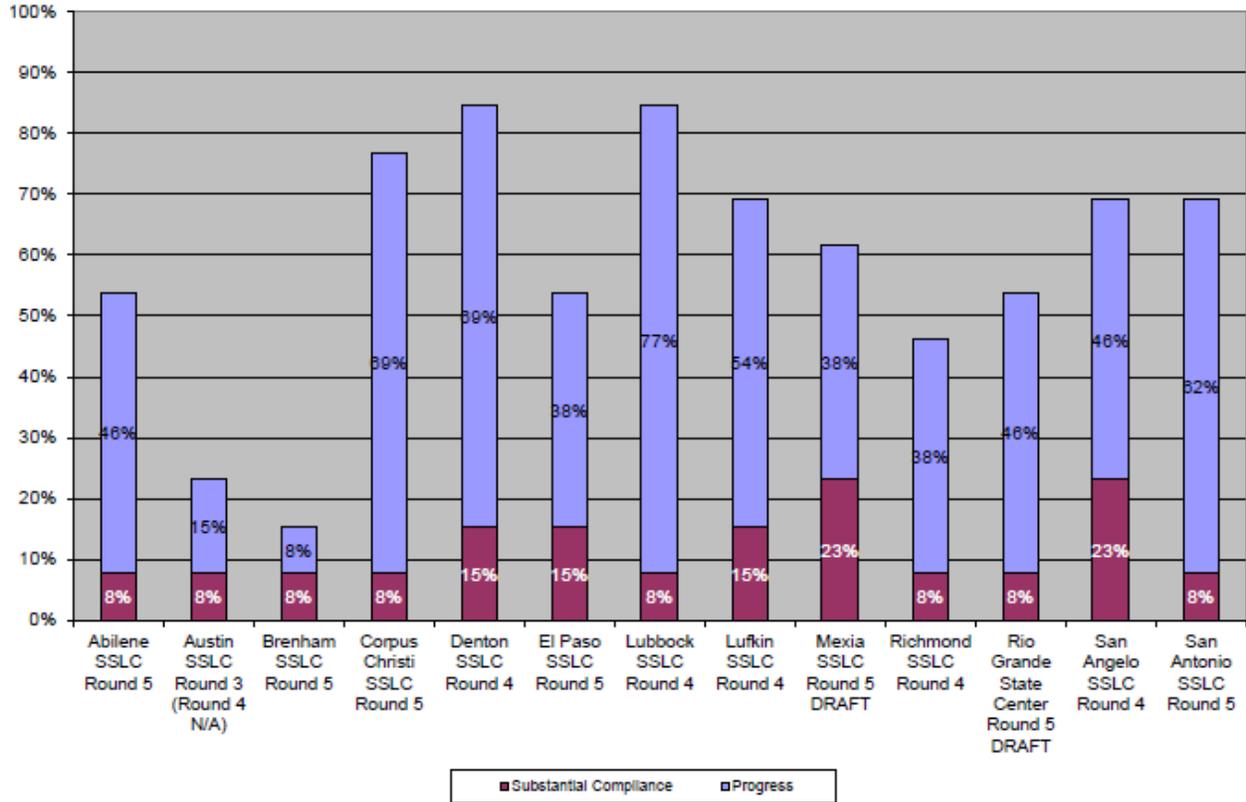
**State Supported Living Centers
 Department of Justice Settlement Agreement
 Section J - Psychiatric Services
 15 Items in this Section**

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



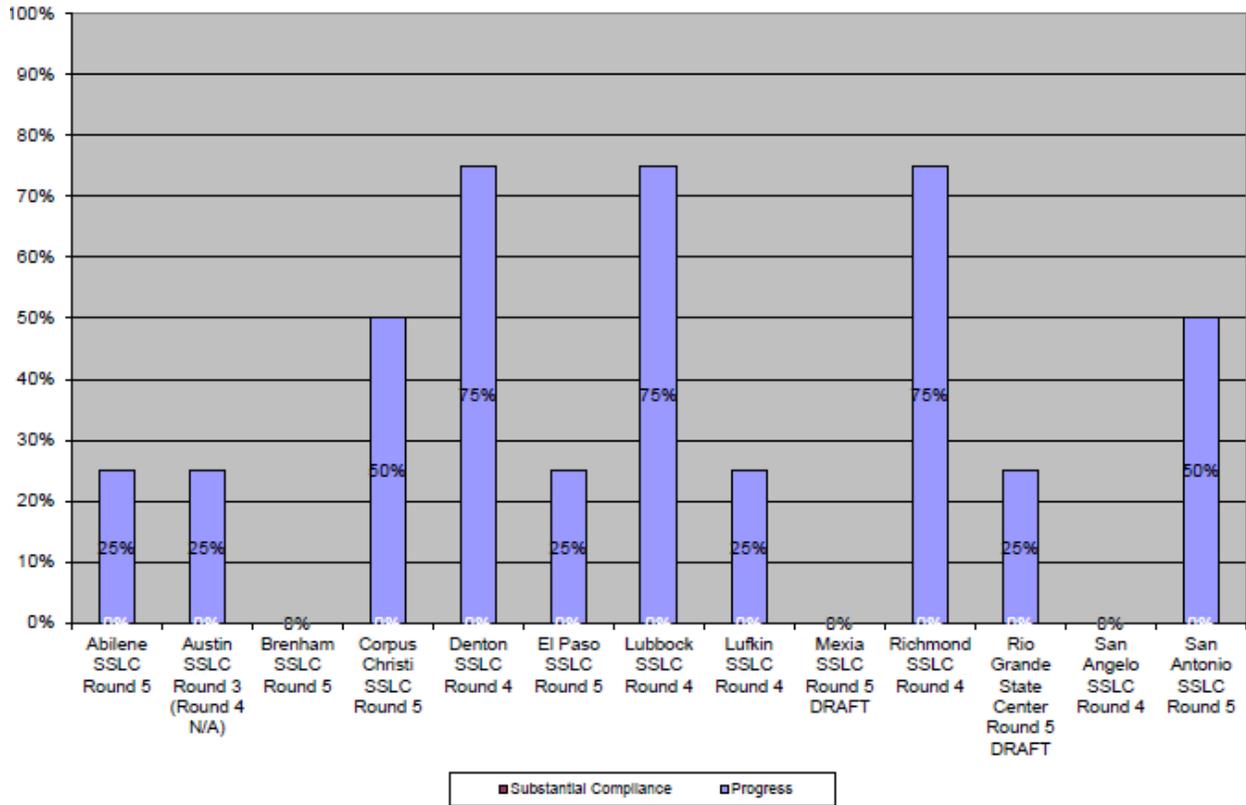
**State Supported Living Centers
Department of Justice Settlement Agreement
Section K - Psychological Services
13 Items in this Section**

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



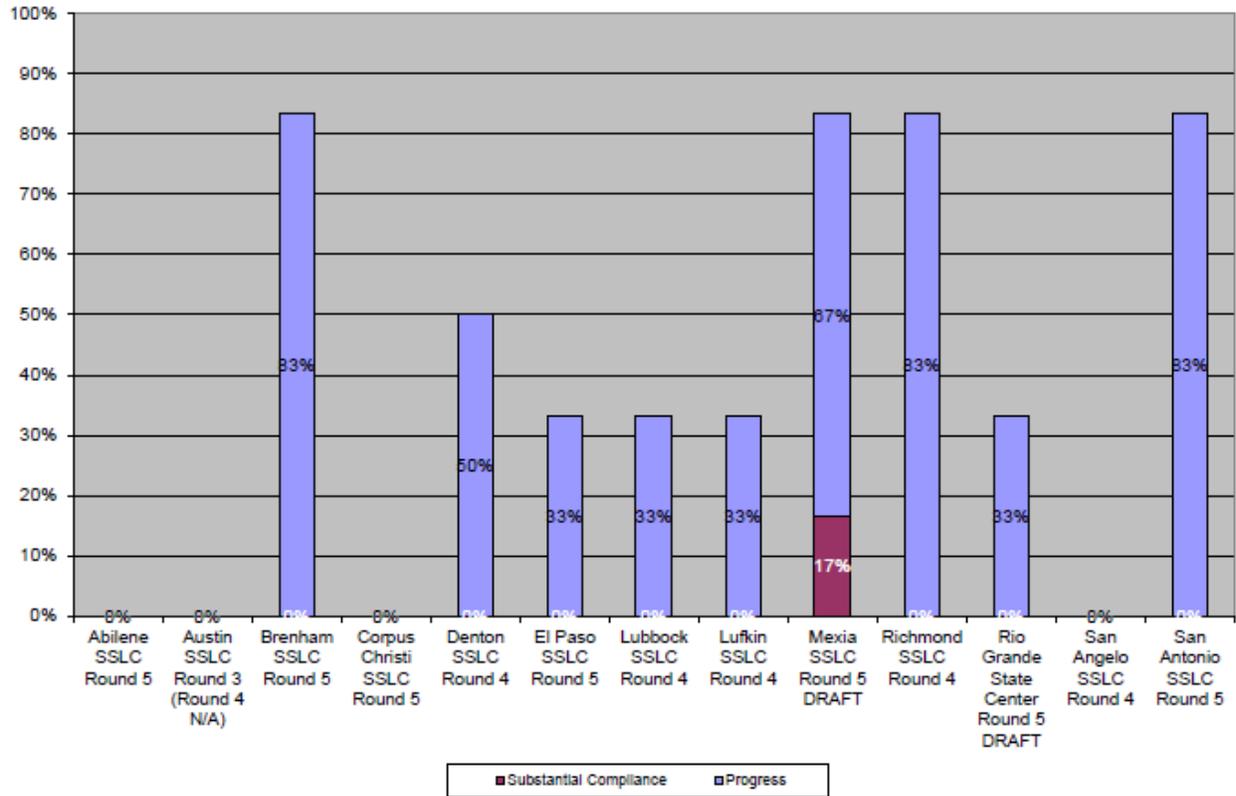
State Supported Living Centers
Department of Justice Settlement Agreement
Section L - Medical Care
4 Items in this Section

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



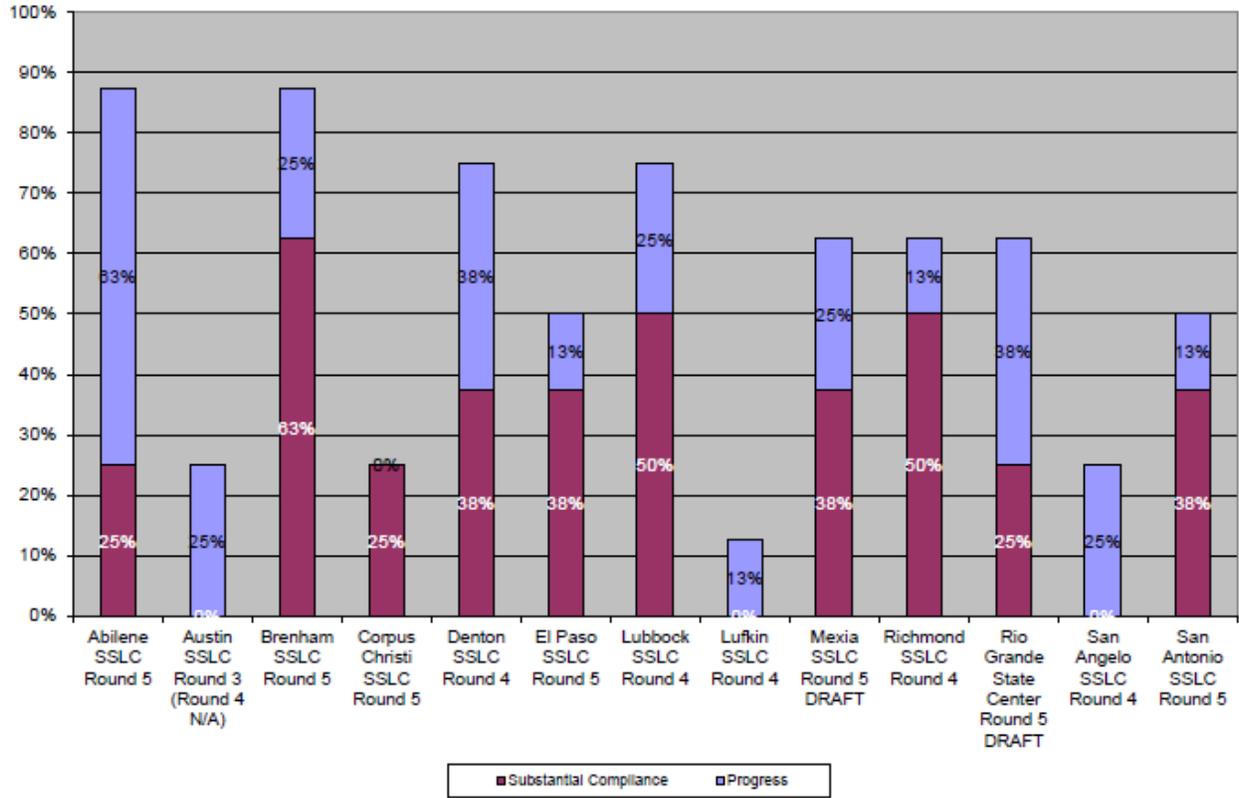
**State Supported Living Centers
 Department of Justice Settlement Agreement
 Section M - Nursing Care
 6 Items in this Section**

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



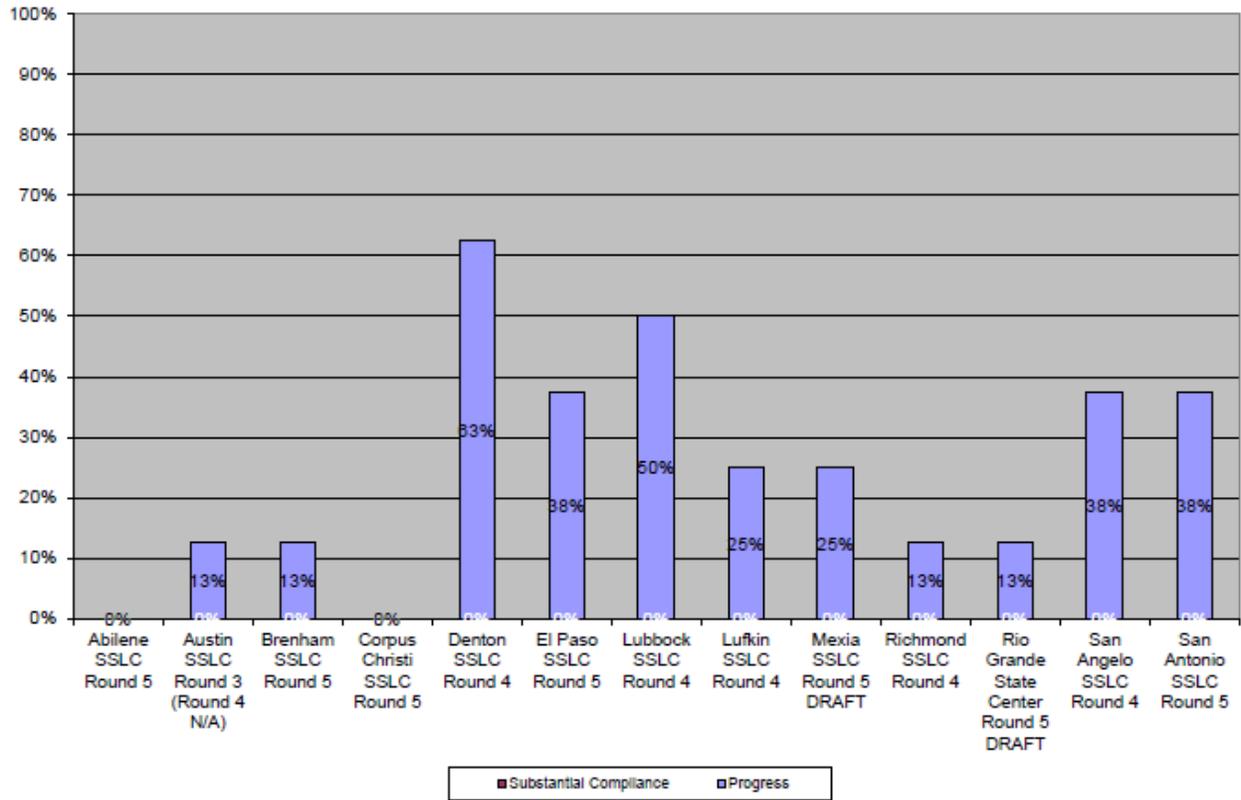
**State Supported Living Centers
 Department of Justice Settlement Agreement
 Section N - Pharmacy Services
 8 Items in this Section**

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



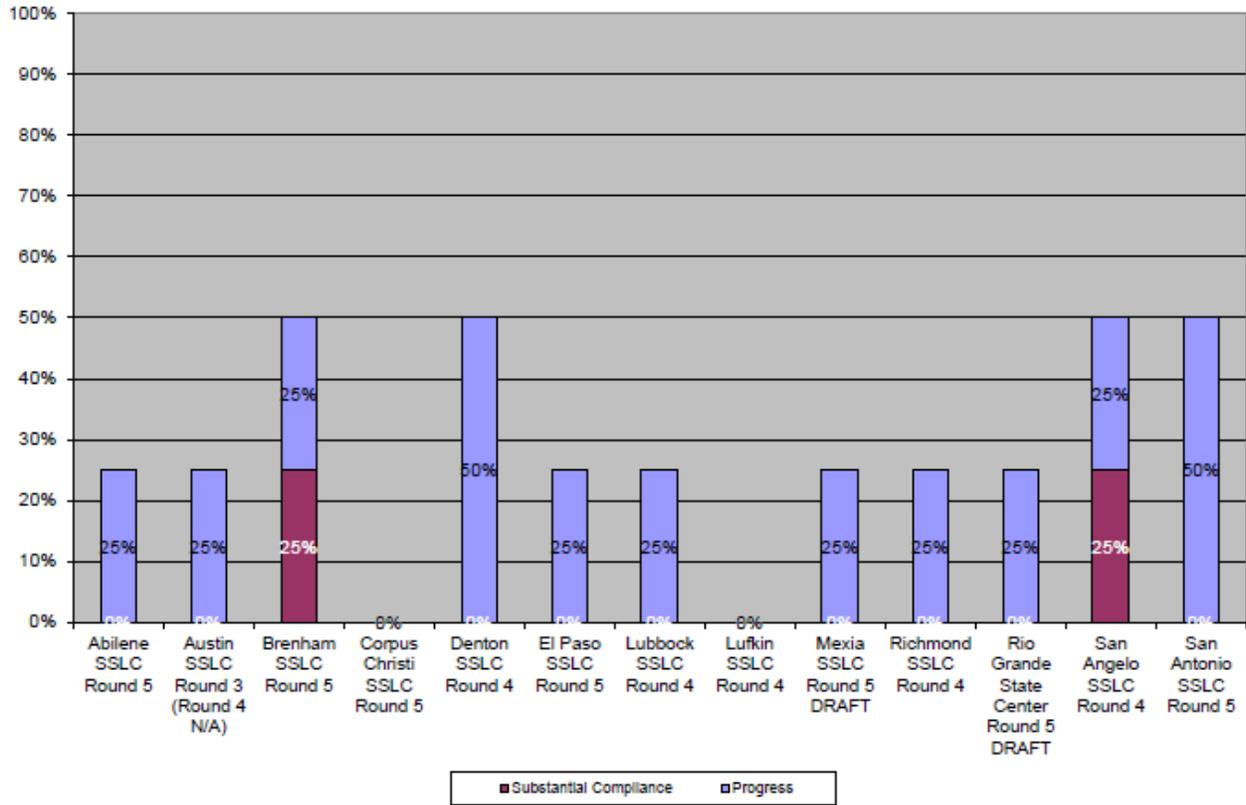
State Supported Living Centers
Department of Justice Settlement Agreement
Section O - Physical & Nutritional Mgmt
8 Items in this Section

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



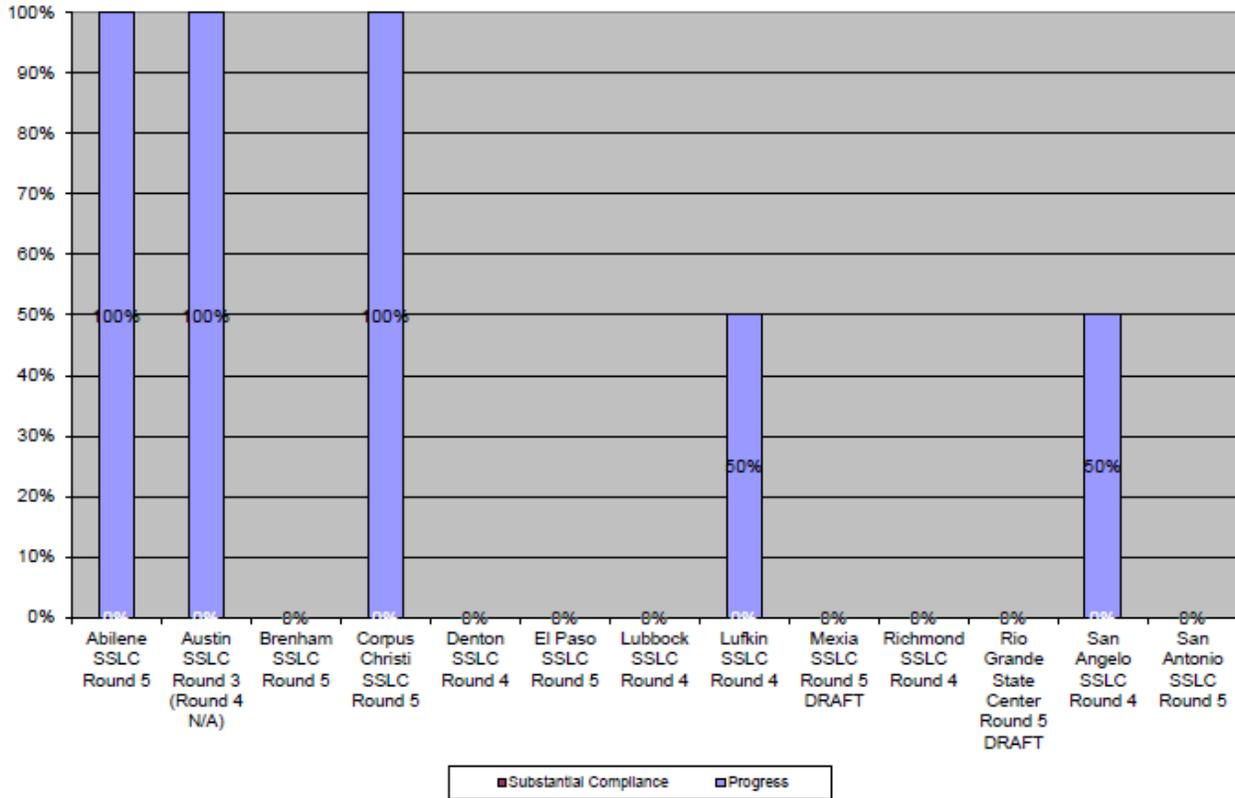
State Supported Living Centers
Department of Justice Settlement Agreement
Section P - Physical & Occupational Tx
4 Items in this Section

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



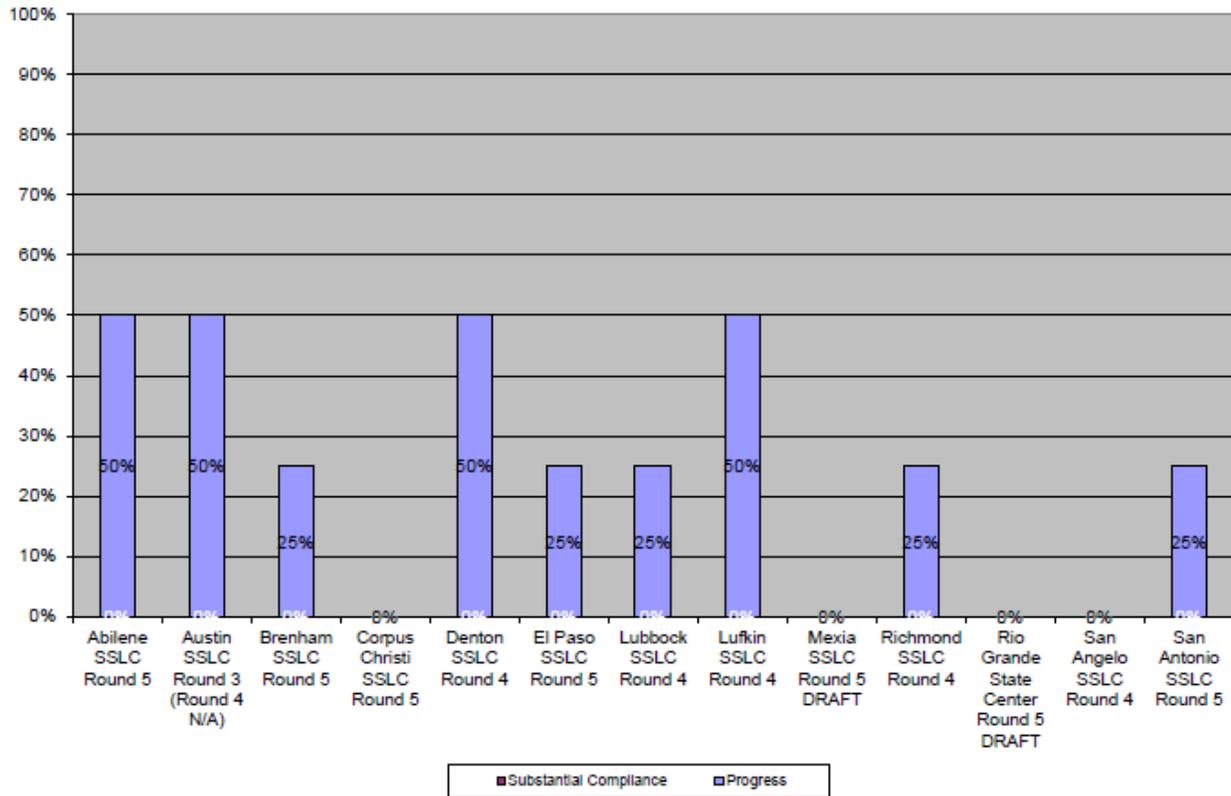
**State Supported Living Centers
 Department of Justice Settlement Agreement
 Section Q - Dental Services
 2 Items in this Section**

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



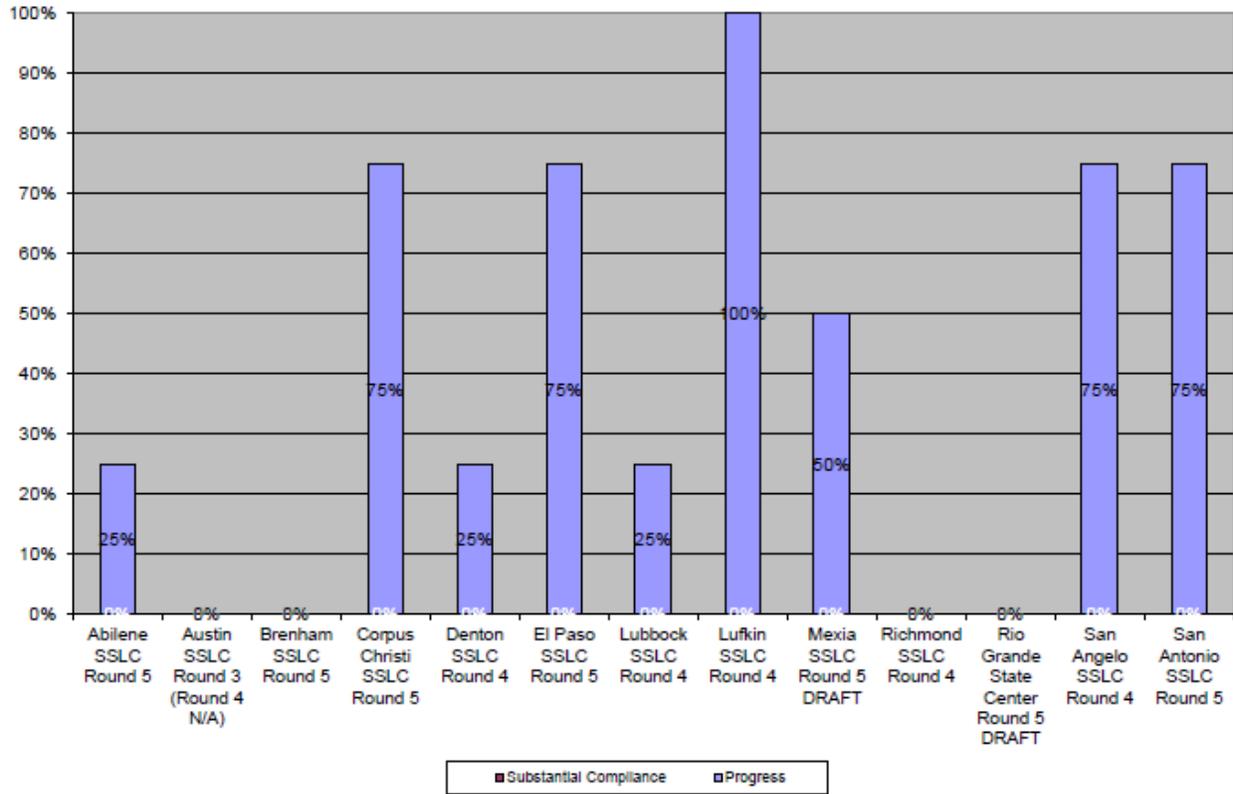
**State Supported Living Centers
 Department of Justice Settlement Agreement
 Section R - Communication
 4 Items in this Section**

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



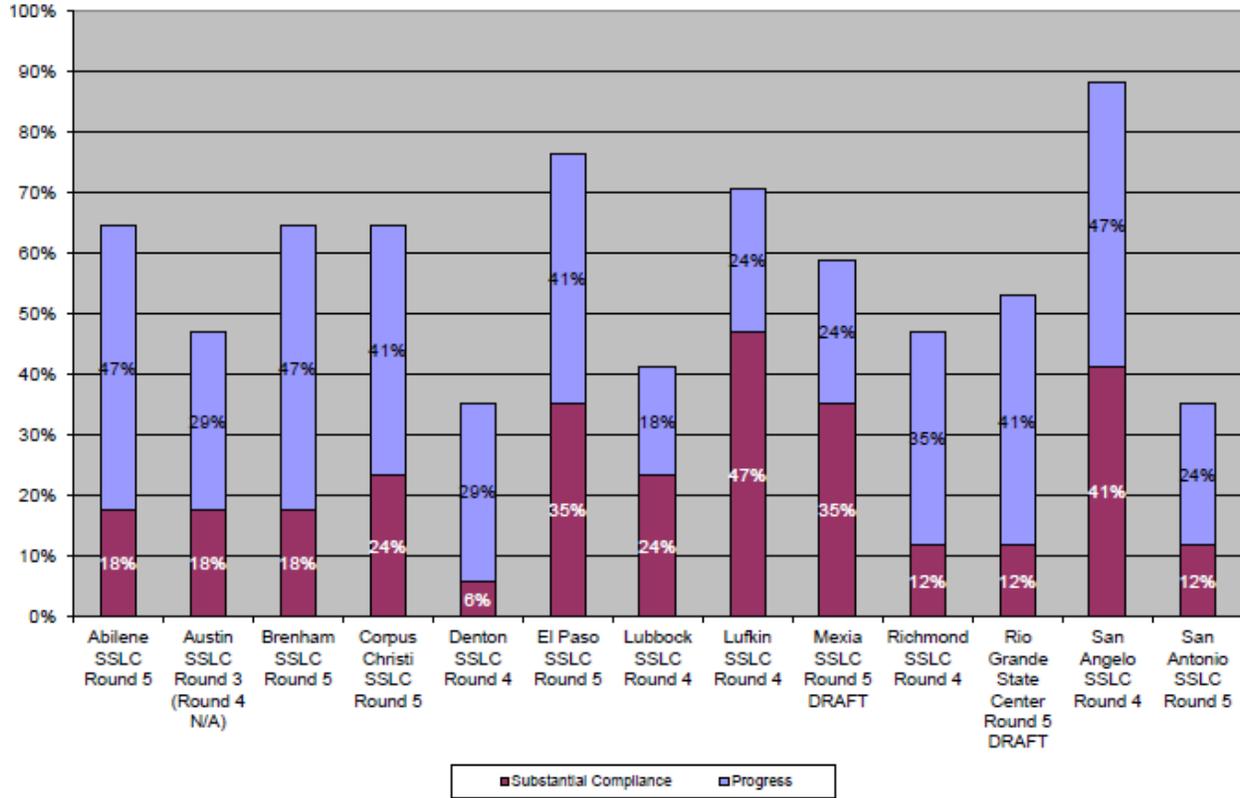
State Supported Living Centers
Department of Justice Settlement Agreement
Section S - Habilitation Services
4 Items in this Section

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



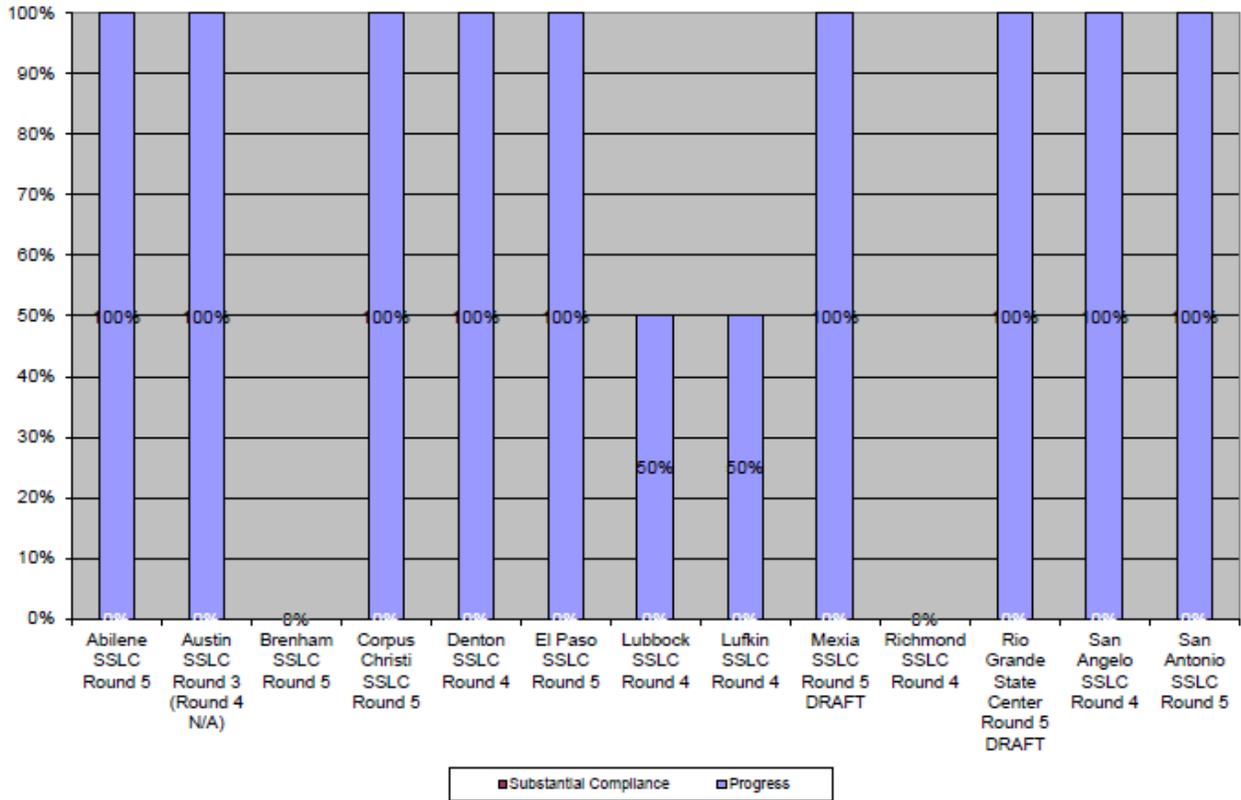
**State Supported Living Centers
 Department of Justice Settlement Agreement
 Section T - Most Integrated Setting
 17 Items in this Section**

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



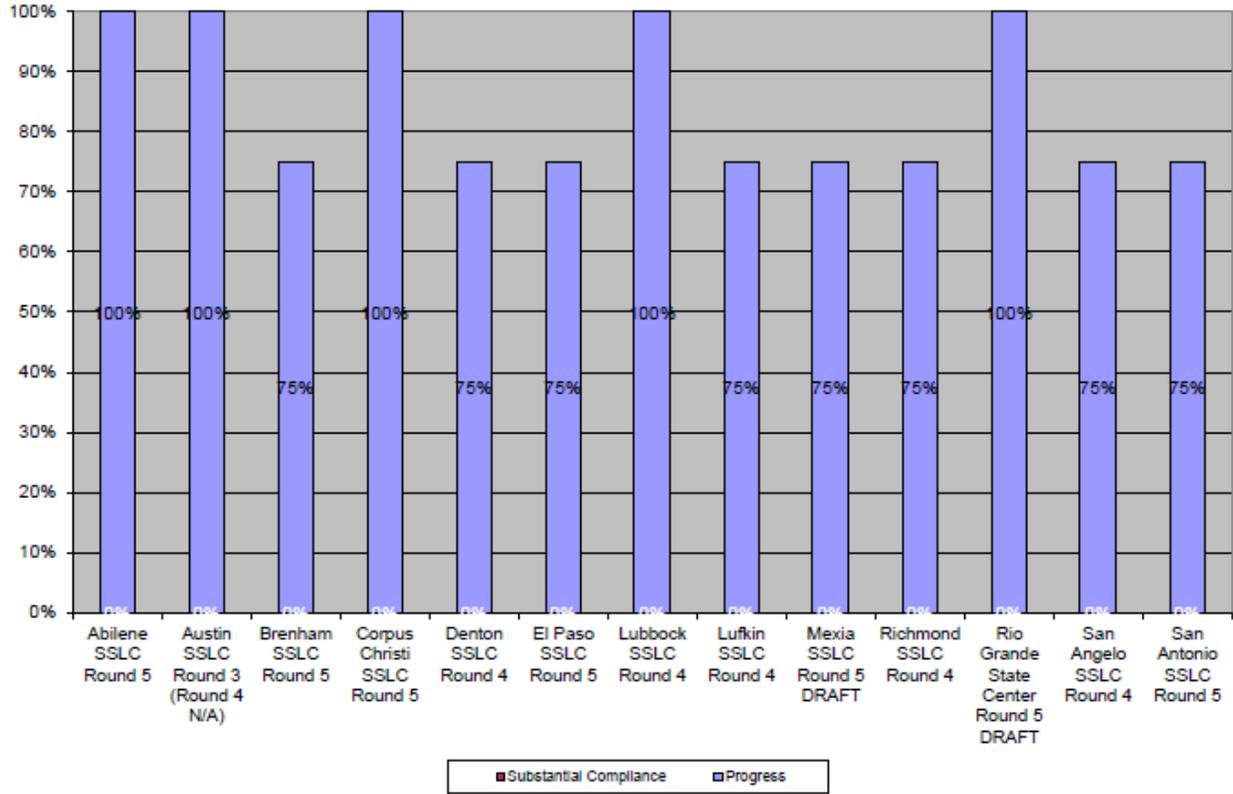
**State Supported Living Centers
 Department of Justice Settlement Agreement
 Section U - Consent
 2 Items in this Section**

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



**State Supported Living Centers
 Department of Justice Settlement Agreement
 Section V - Recordkeeping
 4 Items in this Section**

Percentage of Scored Items Showing Substantial Compliance and Progress through Most Recent Review



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FAX: (512) 463-1017
DIAL 711 FOR RELAY CALLS

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MAVERICK COUNTY COURTHOUSE
501 EAST MAIN STREET, SUITE 114
EAGLE PASS, TEXAS 78852
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The Senate of The State of Texas



Senator Carlos Uresti District 19

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PECOS, TEXAS 79772
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FAX: (432) 447-0275

DIAL TOLL FREE: 1-800-459-0119

December 10, 2012

Re: Senate Health & Human Services Committee Interim Charge 9b and Medicaid Block Grants

I want to thank Chairwoman Nelson and my other colleagues on the Senate Health and Human Services Committee for the hard work on this report and all of the committee's interim charges. It is an honor to serve with you, and I know that each of us has the best interest of Texas at heart, though we may disagree on details from time to time.

While I proudly attach my signature to the committee's report, I must express my concern regarding block grants. I do not believe that block grants are the preferred solution to the rising cost of Medicaid in Texas. Because the cost of health care tends to increase more rapidly as compared to other goods and services, block granting of Medicaid funds—even if tied to population growth and inflation—would ultimately reduce the amount of federal funds that Texas receives for this much needed program.

I commend the chair and all the members for their work on other improvements to the Texas Medicaid system, and I look forward to working with you to build upon these gains in the upcoming 83rd session.

Sincerely,

A handwritten signature in cursive script that reads "Carlos Uresti".

CARLOS I. URESTI

CIU/mar/ml