TEXAS SENATE
COMMITTEE ON HEALTH AND HUMAN SERVICES

INTERIM REPORT
TO THE
80TH LEGISLATURE

December 2006

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THE SENATE OF TEXAS
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December 1, 2006

The Honorable David Dewhurst
Lieutenant Governor of Texas
P.O. Box 12068
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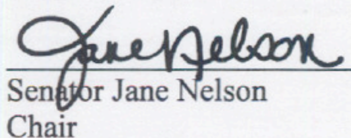
Dear Governor Dewhurst:

The Senate Committee on Health and Human Services submits this report in response to the interim charges you have assigned to this Committee. The Committee held six public hearings to consider invited and public testimony from affected consumers, health and human service providers, and agency personnel regarding all of its charges. This report includes a review of issues and makes recommendations related to mental health services, Medicaid reform, health care workforce shortages, Federally Qualified Health Centers, vaccination rates and supply, nutrition and physical activity, implementation of child and adult protective services reform, use of the 2-1-1 Information Network, and implementation of House Bill 2292. Please note that the three jointly assigned interim studies will be addressed in a separate report.

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

Respectfully submitted,



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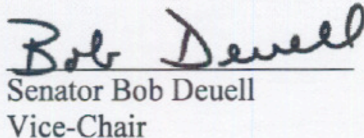

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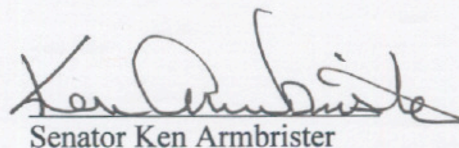

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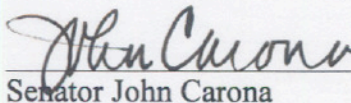

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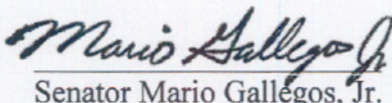

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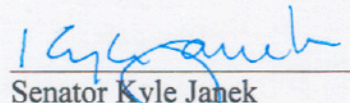

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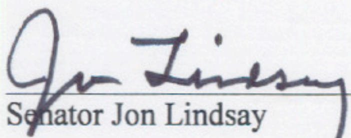

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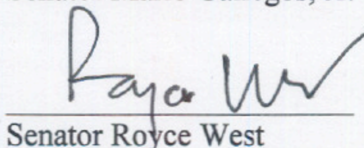

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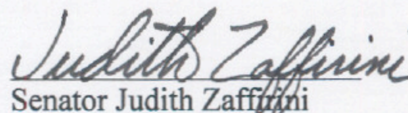

Senator Judith Zaffirini

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Charge 1: Improving Delivery of Texas' Mental Health Services

Study and make recommendations for improving delivery of Texas' mental health services; consider local and regional delivery systems including access to care, cost-effectiveness, choice and competition, and quality of care.

The Public Mental Health Care System in Texas

The traditional public mental health system in Texas is considered to be 41 mental health and mental retardation (MHMR) centers providing community-based services combined with the ten state hospitals when intense, inpatient treatment is necessary. For the 2006-2007 biennium, the Department of State Health Services (DSHS) received $715.2 million for adult and children's community-based mental health care ($586.1 and $129.1 million, respectively).[1] The Dallas Area NorthSTAR Authority (DANSA) is a separate Medicaid managed care system providing only mental health and substance abuse services. Biennial funding for the seven-county NorthSTAR area totals $195.7 million.[2] DSHS also provides substance abuse prevention, intervention, and treatment using $319.1 million, including $45.6 million of general revenue and $275.6 million from the federal Substance Abuse Prevention and Treatment (SAPT) block grant.[3] Funding for the ten

[1] Legislative Budget Board, *Fiscal Size-Up 2006-07 Biennium.* (December 2005). p. 148.
[2] Legislative Budget Board, *Fiscal Size-Up 2006-07 Biennium.* (December 2005). p. 148.
[3] Legislative Budget Board, *Fiscal Size-Up 2006-07 Biennium.* (December 2005). p. 149.

state hospitals in 2006-2007 totals $573 million, and the three mental health community hospitals located in Houston, Galveston, and Lubbock, received $40.3 million.[4]

Some stakeholders question how accurately this traditional view reflects the array of state-funded services provided to mental health consumers. A broader view of the public mental health system includes other state and local agencies, emergency rooms, and not-for-profit organizations. The total dollar amount spent by agencies on mental health is unclear because these budgets may be tied to other services.[5] In 2004, examples of other agencies providing mental health services, along with their respective expenditures, included: [6]

Agency		Amount	
Health and Human Services Commission (HHSC)	$	225.30	million
Texas Education Agency (TEA)	$	182.00	million
Texas Department of Criminal Justice (TDCJ)	$	56.90	million
Department of Family and Protective Services (DFPS)	$	12.10	million
Department of Aging and Disability Services (DADS)	$	11.90	million
Governor's Criminal Justice Division (CJD)	$	5.70	million
Texas Youth Commission (TYC)	$	2.63	million
Texas Juvenile Probation Commission (TJPC)	$	1.90	million
Department of Assistive and Rehabilitative Services (DARS)	$	1.46	million
Texas Department of Housing and Community Affairs (TDHCA)	$	.47	million

Many of these agencies provide similar types of mental health services to shared clients, often with little coordination or data-sharing between them. These "silos" may hinder a mental health consumer's ability to navigate the system efficiently, and may also lead to overlap and redundancy among the different state agencies and healthcare providers.

[4] Legislative Budget Board, *Fiscal Size-Up 2006-07 Biennium.* (December 2005). p. 151. Online.
[5] Texas Mental Health Transformation: Assessment of Needs and Resources, *Chapter 3: Transformation Drivers,* p. 20.
[6] *Ibid.*

Hospital Spending on Mental Health Care

Public and private hospitals that provide mental health services sometimes bear high costs from treating people with mental illness during emergency and inpatient visits. Evidence from Saint David's Healthcare Partnership in Austin suggests that people with mental illness may choose to go to an emergency room because they cannot be turned away, and also to interact with other people or healthcare providers.[7] They also may be brought in by family or law enforcement for attention.[8] In 2003 and 2004, among 477 Saint David's inpatients with a mental health- or substance abuse-related diagnosis, total charges for ER visits and admissions were $13 million (while total cost was over $3 million).[9]

Community MHMR Centers

The 41 MHMR centers together serve every county in Texas, and all have dual roles as both mental health authorities (MHAs) and direct service providers. The exception is NorthSTAR, which functions as an MHA only. In their MHA roles, the centers contract with local providers to arrange mental health and substance abuse services for their clients. In their provider roles, as clarified by Section 2.74 of HB 2292, the MHMR centers must serve as "providers-of-last-resort" (POLR) and are required to prove that every reasonable attempt has been made to form an appropriate base of private

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[7] Interview by Katherine Barksdale and David Warner with Keith Morris, Associate Director, Behavioral Health Services, Austin Travis County Mental Health Mental Retardation Center, Austin, Texas, February 28, 2006.

[8] Interview by Katherine Barksdale with Daisha Davis, LMSW, Emergency Room Social Worker, Saint David's Medical Center, Austin, Texas, March 13, 2006.

[9] Lyndon B. Johnson School of Public Affairs, *Reducing the Cost of Uncompensated Care,* Policy Research Project (Austin, TX, 2006).

providers.[10] The centers' dual roles have come under much scrutiny in recent years, as they serve as both a front door to services and also a direct competitor. HB 2292's amendment to the Texas Health and Safety Code § 533.035 increased already existing tension between private providers and MHMR centers and did not fully address potential conflicts of interest caused by the dual roles of the MHMR centers.[11]

Advocates and other stakeholders have different views, and offer varying solutions to the dual functions of the MHMR centers and on the POLR requirement. Two bills in the 79th Legislative Session, HB 470 and HB 2572, synthesize the competing views of various stakeholders, although neither was enacted into law.

HB 470 proposed significant reorganization of the current mental health system and would have reduced the existing 41 local authorities to ten regional authorities. In addition to mandating that no authority could also function as a provider, the bill would have phased in a change from the current method of pre-paying local authorities based on a funding formula to a fee-for-service model where MHMR centers would be reimbursed after the provision of services.[12] HB 470 also would have required local MHMR authorities to design systems of care resources for children with serious emotional disturbance (SED). Serious emotional disturbance is the term used to describe mental illness in children, rather than seriously mentally ill (SMI). HB 470 was reported favorably by the House Human Services Committee but did not pass the full House.

[10] *Ibid*., p. 7.
[11] Carole Smith, Executive Director of Private Providers Association of Texas, *Presentation to the House Human Services Committee,* Written testimony submitted to the House Human Services Committee (May 24, 2006). (Copy on file with the Senate Health and Human Services Committee).
[12] Texas House Bill 470, 79th Legislature, regular session (2005).

HB 2572 proposed that the current system of 41 local authorities remain in place but attempted to repeal the POLR provision created in HB 2292. Supporters argued that not enough private providers are available to meet the need that would be created if local MHMR centers could not also serve as providers in some parts of Texas. Furthermore, there was concern that if a private provider went bankrupt or left the service area, and if the local MHMR center had not been permitted to provide services, no one would be prepared to quickly step in to deliver services. It would make MHMR centers financially unviable if they were forced to implement the provider of last resort requirement, supporters argued.[13] Opponents of HB 2572 pointed again to the inherent conflict of interest resulting from local MHAs serving as both state funded administrators and service providers. On June 17, 2005, Governor Rick Perry vetoed HB 2572, contending that it failed to adequately address this conflict of interest.[14] He also ordered a negotiated rulemaking process through which an implementation plan for the POLR requirement would be developed.[15] The rulemaking process began in October 2006 and is expected to be completed by December 15, 2006.

State Mental Health Facilities (SMHF)

[13] House Research Organization, *Focus Report: Vetoes of Legislation, 79th Legislature,* (July 29, 2005), p. 16.
[14] Governor of the State of Texas, *Proclamation Related to House Bill 2572.* Available: http://www.governor.state.tx.us/divisions/press/bills/veto2005/veto2005_files/hb2572.pdf. Accessed June 30. 2006.
[15] Governor of the State of Texas, *Executive Order RP 45,* June 17, 2005.

In order to be admitted as a civil inpatient to one of Texas' state hospitals, the proposed patient must be considered a danger to themselves or others.[16] The ten SMHFs are currently funded to accommodate 2,477 patients, a number that has remained relatively static for several years.[17] An analysis of SMHF utilization indicates that the number of admissions is increasing, while the length of stay is becoming shorter. This trend shows no signs of reversing in the near future and supports other evidence showing that SMHFs are moving away from providing long-term treatment and residential services and toward acute care. This trend has resulted in higher per-patient costs, as these patients' acute needs require more expensive, intensive care. In the first quarter of FY 2002, the average cost-per-patient served in all SMHFs was $10,399.[18] By the second quarter of FY 2006, the average cost-per-patient had jumped to $13,094. [19]

Several factors determine the demand for, and utilization of, state mental health facility services, including the availability of community services, demographic growth, and new technologies and medications.[20] From 1993 to 2006, the supply of private psychiatric beds in Texas decreased 45 percent, from 11,000 to 6,000, making the role of SMHFs in providing emergency and specialty treatment services increasingly important.[21]

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[16] Texas Health and Safety Code, Section 574.034(a).
[17] Department of State Health Services, State Hospitals Section, *Mission, Vision, Goals, and 2006 Work Plan,* p. 26. Available: http://www.dshs.state.tx.us/mhreports/MhBook62.pdf. Accessed: June 15, 2006.
[18] Department of State Health Services, State Mental Health Facilities Division, *Mission, Vision, Goals, and 2004 Work Plan,* p. 77. Available: http://www.dshs.state.tx.us/mhreports/MhBook41.pdf. Accessed: June 15, 2006.
[19] Department of State Health Services, State Hospitals Section, *Mission, Vision, Goals, and 2006 Work Plan,* p. 41. Available: http://www.dshs.state.tx.us/mhreports/MhBook62.pdf. Accessed: June 15, 2006.
[20] Department of State Health Services, Program Statistics and Planning, *Report Update for State Mental Health Facilities,* (Austin, Tex., April 2005), p. 8.
[21] Department of State Health Services, *Texas Health and Human Services System Strategic Plan: 2007-2011,* p. 9. Online: Available: http://www.dshs.state.tx.us/council/agendas/030206/2StrategicPlanChapIX.pdf (draft). Accessed: June 19. 2006.

Another indicator of unmet need in the community is the SMHF occupancy rate. In November 2003 only one SMHF, North Texas State Hospital, was over 100 percent occupancy. By February 2006, five facilities were at 100 percent occupancy or above. As state hospitals become too crowded, patients must be diverted to other facilities, even when those facilities are hours away. For example, Austin State Hospital reported reaching capacity on 57 different occasions between September 1, 2004 and July 31, 2005, resulting in the re-directing of patients to other state hospitals.[22] Transporting patients creates a strain on the local law enforcement officers, most of whom have little training on mental illness issues but typically must drive these patients to the receiving facility. Furthermore, stakeholders often speak of the "revolving door" of services, where people with mental illness continually cycle through different systems (i.e., criminal justice, education, MHMR centers, and state hospitals), although in the second quarter of FY 2006, 43 percent of patients admitted to SMHFs were new to that system.[23]

Community-based vs. Inpatient Services

Texas spends most of its mental health budget on community-based services, rather than inpatient care at state mental health facilities. Inpatient hospitalization, as noted earlier, is very expensive but is also necessary in some cases. On average, it costs six times more to treat someone in an inpatient setting than in the community.[24] In 2005, 169,284 people

[22] Community Action Network, *Adult Mental Health,* Available: http://caction.org/IssuesAreas/faqs/AMH_August2005.pdf. Accessed: June 10, 2006.
[23] Department of State Health Services, State Hospitals Section, *Mission, Vision, Goals, and 2006 Work Plan,* p. 206. Available: http://www.dshs.state.tx.us/mhreports/MhBook62.pdf. Accessed: June 15, 2006.
[24] Mental Health Association in Texas, *Turning the Corner: Toward Balance and Reform in Texas Mental Health Services,* (Austin, Tex., 2005), p. 2-16.

were treated in the community at a cost of $2,546 per patient, compared with 16,880 who were treated as inpatients at $16,960 per person.[25]

Since the implementation of Resiliency and Disease Management in September of 2003 (FY 2004), the number of Texans waiting to be served by their local MHMR center has increased. From November 30, 2004 to February 28, 2006, the target population state-wide waitlist more than doubled from 603 people to 1,319.[26] The Austin Travis County MHMR Center (ATCMHMR) began a waitlist for its services, for the first time in its 38-year history, in the spring of 2005. In the ten month period from March 2005 through December 2005, ATCMHMR's waitlist increased from 12 people to 471.[27] As of June 19, 2006, the number of people on the waitlist was 304.[28] Currently, to be eligible for ATCMHMR services, adults must have one of the three target diagnoses and be severely functionally impaired. However, unless they also are 1) already receiving Medicaid, 2) newly released from Austin State Hospital (ASH), or 3) released from jail or prison within the last 30 days, they will be placed on the waitlist. While on the waitlist, currently averaging six to eight months in Travis county, individuals do not receive needed treatment and can deteriorate while waiting long periods for services.[29]

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[25] *Ibid*., p. 2-16.
[26] Department of State Health Services, *Implementation of Resiliency and Disease Management and Jail Diversion Programs for Mental Health Clients in Texas: An Update as Requested by the Texas Senate Health and Human Services Committee,* p. 6, (June 2006).
[27] Mayor's Mental Health Task Force Monitoring Committee, "Austin Travis County Behavioral Health Service System," Presentation to the Health and Human Services Subcommittee of the Austin City Council, Austin, TX, January 31, 2006, p. 5.
[28] Telephone interview by Katherine Barksdale with Keith Morris, Associate Director, Behavioral Health Services, Austin Travis County Mental Health and Mental Retardation Center, Austin, Texas, June 19, 2006.
[29] Andrea Ball, "Future is Uncertain for Mental Health Care," *Austin-American Statesman* (July 2, 2006).

Crisis Services

People who do not meet the diagnostic criteria for RDM are only eligible to receive crisis services from their local MHMR, for which there is no waitlist. Instead, the goal is to provide a brief intervention in the community that will ease the crisis situation and prevent the person from using more intensive services.[30] In FY 2005, the MHMR centers provided crisis services to 52,585 unique individuals.[31] Since the implementation of RDM on September 1, 2003, crisis visits to Psychiatric Emergency Services (PES) in Austin had increased 84.8 percent by August 31, 2005.[32] As the only 24-hour public mental health crisis center in Austin, PES' utilization trends clearly indicate a lack of community-based services available for people who have not yet reached a state of crisis. Early intervention could allow individuals to avoid reaching the crisis stage.

Crisis Services Redesign

Community MHMR centers are required to provide a minimum array of mental health services, including crisis stabilization. Crisis services, essential in providing a complete continuum of care at the community level, treat individuals who could hurt themselves or others, be hurt by others, or could end up in jail or homeless due to worsening symptoms of chronic mental illness.[33] Crisis services are also a common way to gain entry into

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[30] Austin Travis County Mental Health and Mental Retardation Center (ATCMHMR), "Adult Utilization Management Guidelines," *Service Package: Crisis (SP-0),* October 20, 2005, p. 19.
[31] Texas Mental Health Transformation: Assessment of Needs and Resources, *Chapter 3: Transformation Drivers,* p. 12.
[32] Andrea Ball, "Future is Uncertain for Mental Health Care," *Austin-American Statesman* (July 2, 2006).
[33] Texas Department of State Health Services, *Crisis Redesign Services,* p. 3. (August 2006).

ongoing mental health services, and are critical in determining whether or not a person will have a positive or negative attitude toward the mental health system.[34]

During the health and human services restructuring following HB 2292, RDM was implemented without an added crisis services component. In 2005, to better address the needs of people with mental illness experiencing a crisis, a Crisis Redesign Committee was formed within DSHS. Several areas in particular became the Committee's focus during the formulation of the Redesign Plan. These included the need for better transportation, the creation of a crisis hotline, and establishing more 23-48 observation facilities.[35] To fund these crisis services, DSHS has requested an exceptional item for $82.3 million in the 2007-2008 biennium.[36] Public meetings throughout the state were also conducted, and because transportation was the most difficult and prevalent problem facing people in crisis, the Committee responded by strongly recommending a regional transportation system to relieve counties and law enforcement of mental health transportation responsibilities.[37]

Mental Health Transformation in Texas

Recognizing that many state agencies provide redundant, fragmented services to Texans with mental health needs, Governor Perry applied for a five-year Mental Health Transformation State Incentive Grant from the federal Substance Abuse Mental Health Service Administration (SAMHSA). Texas was awarded the roughly $10 million grant

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[34] *Ibid.*
[35] *Ibid.*
[36] *Ibid.*
[37] Texas Department of State Health Services, *Crisis Services Redesign Committee Overview,* p. 1. (June 22, 2006).

in October 2005 and a Transformation Work Group (TWG) was formed to work in two primary areas: developing and supporting local behavioral health collaboratives, and using cutting edge technology to change work processes across the TWG agencies. There will also be an emphasis on increasing cultural competencies and reducing cultural and geographic health disparities. The TWG is composed of consumers and family members and representatives of the Office of the Governor, the Legislature, and 14 state agencies.[38] The input of this work group is crucial to improvements in the mental health system as a whole; hence, recommendations from the TWG are reflected in this report. The ongoing work of the TWG will play an important role in fine-tuning initiatives necessary to transform mental health policy in Texas.

Prior to receiving the transformation grant, several data-sharing initiatives were already underway to improve the state-wide service delivery system by increasing communication within, and among, different organizations and health care providers. These information technology efforts have the potential to reduce the inefficient expenditures of funds, and also may contribute to better patient outcomes.

One initiative is the Behavioral Health Integrated Provider System (BHIPS), which was developed by the Texas Commission on Alcohol and Drug Abuse as an electronic health record system for substance abuse clients. Rolled out between June 2001 and November 2002, the web-based application was designed to improve "consistency and quality of care, accuracy and completeness of data, information sharing and continuity of care,

[38] Mental Health Transformation in Texas. Online: Available: http://www.mhtransformation.org/. Accessed November 13, 2006.

compliance with state and federal reporting requirements," among other functions.[39] In October 2006, the Healthcare Information and Management Systems Society presented DSHS with the Nicholas E. Davies Award of Excellence for BHIPS. The national award recognizes health care groups for their use of information technology.[40]

A second DSHS initiative to increase the sharing of information across service providers is Clinical Management for Behavioral Health Services (CMBHS). This program seeks to combine the substance abuse system (BHIPS) with the mental health data system (CARE), to provide more complete client information to health care providers, better reports to state and federal agencies, and to eliminate inefficiencies created by maintaining two different data systems.[41]

Prevalence of Mental Illness in Texas

In 2005, Texas had an estimated adult population of 16.3 million. Of these adults, roughly one in five, or 3.6 million, will have a mental illness at any given time.[42] The prevalence of mental illness in Texas children and adolescents is similar to that of the

[39] Texas Department of State Health Services, *BHIPS Overview*, Available: http://www.dshs.state.tx.us/sa/BHIPS. Accessed: July 16, 2006.
[40] Texas Department of State Health Services, *DSHS Receives National Health Care Technology Award,* Available: http://www.dshs.state.tx.us/news/releases/20061016.shtm. Accessed: October 18, 2006.
[41] Texas Department of State Health Services, Clinical Management for Behavioral Health Services, Available: http://www.dshs.state.tx.us/cmbhs/default.shtm. Accessed: October 18, 2006.
[42] Texas Department of State Health Services. 2001-2005 Adult Mental Health Prevalence/Priority Population Data. Available: http://www.dshs.state.tx.us/mhreports/01-05RevisedMHAdultPre-iPopData.pdf. Accessed: June 16, 2006.
[43] *Ibid.*

adult population. An estimated 1.2 million of 6.1 million Texans under the age of 18 have or are at risk of having mental health problems.[43]

Priority and Target Populations

Prior to 2003, the "priority population" eligible to receive state-funded mental health services, as defined in the Texas Health and Safety Code, § 533.0354, was composed of adults having severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.[44] In 2003, the Legislature passed House Bill 2292, which directed the DSHS to refocus resources on a subset of the priority population, thus making a new "target population." This target population was defined as adults having schizophrenia, bipolar disorder, or major depression, and children with SED. Upon meeting the diagnostic criteria, this population was targeted to receive intensive and ongoing services using a disease management approach, referred to as Resiliency and Disease Management (RDM).[45] This new target shifted the criteria for service eligibility towards a specific diagnosis in order to focus limited resources on those with the best chance of responding to treatment and services.

Adults

Adults diagnosed with schizophrenia, bipolar disorder, and major depression are believed to compose over 90 percent of the clients who currently receive care through the

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[44] Texas Health and Safety Code, Chapter 533, Section 0354.
[45] Texas House Bill 2292, 78th Texas Legislature, 2003.

traditional public mental health system.[46] Local mental health authorities do have the authority to make exceptions for individuals with other severe mental illnesses, including anxiety disorders, chronic depression, and obsessive-compulsive disorder. About 14,000 adults who were previously receiving services are no longer qualified.[47]

The 2005 target population of Texas adults eligible for services was estimated to be 686,759 out of 3.6 million, or 20 percent of mentally ill adults.[48] Only about 25 percent of the target population actually receives mental health services from their local MHMR center.[49] The average number of adults receiving community services each month during 2006 is expected to be 46,143.[50] However, it is estimated that as many as 40 percent of people with serious mental illness do not seek treatment for their illness, and even those who do will not necessarily seek services from DSHS.[51]

Criminal Justice and Mental Illness

Prior to the 1960s, many people with mental illness were housed in state hospitals for long periods of time, often months or years. In 1963, Congress passed the Mental Retardation Facilities and Community Mental Health Centers Construction Act, which

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[46] Hogg Foundation for Mental Health, Legislative Update: A Citizen's Guide to the Mental Health-Related Actions of the 78th Texas Legislature, p. 9. Available: http://www.hogg.utexas.edu/PDF/LegUpdate.pdf. Accessed: June 1, 2006.

[47] Mental Health Association in Texas, Turning the Corner: Toward Balance and Reform in Texas Mental Health Services, (Austin, Tex., 2005), p. 2-11.

[48] *Ibid.*

[49] Morningside Research and Consulting, *Mayor's Mental Health Task Force Final Report,* p. 4. Available: http://www.hogg.utexas.edu/pdf/MHTaskForceFinal.pdf. Accessed: July 28, 2006.

[50] Legislative Budget Board, *Fiscal Size-Up 2006-07 Biennium.* (December 2005). p. 148. Available: http://www.lbb.state.tx.us/Fiscal_Size-up/Fiscal_Size-up_2006-2007_0106.pdf. Accessed: August 16, 2006.

[51] Texas Department of State Health Services, *Mental Health Facts.* Available: http://www.dshs.state.tx.us/mhnews/MentalHealthFacts.shtm. Accessed: July 31, 2006.

gave states grants to construct local centers and encouraged treatment that was community-based, rather than hospital-based.[52] While economically appealing, "deinstitutionalization" in many ways actually shifted people with mental illness out of the state hospitals into communities with a dearth of mental health services. As a result, many people with mental illness, due to their non-violent or substance-related offenses, are often funneled into the criminal justice system instead of into community-based treatment.

Nationally, the number of incarcerated men and women with severe mental illness has increased so dramatically that prisons and jails may now be the largest mental health providers in the United States.[53] However, prisons are not designed to provide the range of services mentally ill prisoners need, and a clear tension exists between the security mission of prisons and mental health considerations.[54] One clear indicator of mental illness in prisons and jails is the suicide rate per 100,000 inmates. In Texas, this rate was 49 per 100,000 for jail inmates and 17 per 100,000 for prison inmates, both higher than national averages.[55]

In Texas, the prevalence of severe mental illness (SMI) among the jail, prison, probation, and parole populations is estimated to be eight percent. However, most researchers

[52] Mental Health Association in Texas, *Turning the Corner: Toward Balance and Reform in Texas Mental Health Services,* (Austin, Tex., 2005), p. 2-3.
[53] Jamie Fellner, "A Correction Quandary: Mental Illness and Prison Rules," *Harvard Civil Rights-Civil Liberties Law Review,* vol. 41, No. 2 (Summer 2006), p. 1.
[54] Jamie Fellner, "A Correction Quandary: Mental Illness and Prison Rules," *Harvard Civil Rights-Civil Liberties Law Review,* vol. 41, No. 2 (Summer 2006), p. 1.
[55] National GAINS Center Policy Research Associates, Inc, "Texas MHT SIG Strategic Analysis Workshop," report prepared by Henry Steadman and Dan Abreu, Austin, TX., May 17, 2006.

consider all of these estimates to be lower than actual prevalence in the Texas criminal justice system, due in part to poor self-reporting and technological gaps across systems.[56]

The Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) was created in 1987 by the 70th Texas Legislature to address the needs of adult and juvenile offenders who have mental illness, mental retardation, and developmental disabilities. Four years later, the role of TCOOMMI was expanded to address offenders with serious medical conditions, physical disabilities, or who are elderly.[57] TCOOMMI is the only program in the country with a Continuity of Care system that covers the entire statewide criminal justice system, with part of this program entailing cross-referencing between the databases of DSHS and the Texas Department of Criminal Justice.[58] To improve the accuracy of data related to screening, assessment, and matches between the two systems, it may be useful for TCOOMMI to report to the Legislature about the prevalence of mental illness on the offender population they serve.

Many organizations and state agencies serve on TCOOMMI's advisory committee including the Texas Education Agency, Texas Juvenile Probation Commission, Health and Human Services Commission, Department of Assistive and Rehabilitative Services, Department of State Health Services, and the Department of Aging and Disability Services. The agency funds both inpatient and community-based programs including jail

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[56] *Ibid.*
[57] Texas Department of Criminal Justice, *The Biennial Report of the Texas Correctional Office on Offenders with Medical or Mental Impairments*. January 28, 2005. Available: http://www.tdcj.state.tx.us/publications/tcomi/TCOMI-Biennial-Report-2005-final.pdf. Accessed: October 16, 2006.
[58] *Ibid*., p. 30.

diversion, outpatient restoration, and mental health and substance abuse treatment. TCOOMMI also attempts to address housing needs due to the difficulties some offenders encounter while looking for a place to live. However, the Texas Department of Housing and Community Affairs is not on TCOOMMI's advisory committee, even though a relationship between them may help achieve their respective missions.

Child and Adolescent Mental Health

The children's mental health priority population consists of children ages 3-17 with a diagnosis of mental illness who exhibit serious emotional, behavioral or mental disorders. They must also:

- have a serious functional impairment,
- be at risk of disruption to a preferred living or child care environment due to psychiatric symptoms, or
- be enrolled in a school system's special education program because of a serious emotional disturbance.[59]

In 2005, it was estimated that of the roughly 6.2 million Texans younger than 18 years of age, 725,000 had a mental illness, while over 1.2 million were at risk for mental health problems.[60] Only about 153,000 meet the criteria for inclusion in the priority

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[59] Texas Health and Human Services Commission, *Texas Health and Human Services System Strategic Plan for FY 2005-2009,* Chapter IX: Department of State Health Services, July 2004. Available: http://www.hhsc.state.tx.us/StrategicPlans/HHS05-09/HHS_StPlan_rv.html. Accessed: June 10, 2006.

[60] Texas Department of State Health Services, *2001-2005 Child/Adolescent Mental Health Prevalence/Priority Population Data* p.50. Available: http://www.dshs.state.tx.us/mhreports/01-05RevisedMHChildPre-PriPopData.pdf. Accessed: June 15, 2006.

population,[61] and about 15 percent, or 23,000, of these eligible children actually receive services through the MHMR system.[62] On average, 9,994 children are expected to receive community mental health services each month during the 2006–07 biennium.[63]

Mental health data on children under the age of six is fragmented. National research suggests that potentially nine percent of children age birth through five have diagnosable emotional and behavioral health concerns.[64] However, although there are over two million children in Texas under the age of five, state data from three known early childhood programs (Head Start, IDEA Part B, and Community Mental Health Centers) shows that less than 5,000 children received state-funded mental health services in 2004 and 2005.[65]

Children's Mental Health and Public Education

Although DSHS is the largest payor of mental health services, TEA is also a key stakeholder. TEA used resources in excess of $182 million in 2004 to provide mental health services to students, an amount over three times that spent by TDCJ.[66] According to a recent report by Texans Care for Children, there is evidence that suggests many children fail early grades due to behavioral problems.[67]

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[61] *Ibid.*
[62] Morningside Research and Consulting, *Mayor's Mental Health Task Force Final Report,* p. 3. Available: http://www.hogg.utexas.edu/pdf/MHTaskForceFinal.pdf. Accessed: July 28, 2006.
[63] Legislative Budget Board, *Fiscal Size-Up 2006-07 Biennium.* (December 2005). p. 148.
[64] Texas Health and Human Services Commission, "Raising Texas: The Texas Early Childhood Comprehensive Systems Plan," Austin, TX, (June 2006), p. 9.
[65] *Ibid.,* pp. 8-9.
[66] Mental Health Transformation State Incentive Grant Workgroup, "Total Spent by State Agencies on Mental Health Services," Austin, Texas, (Spring 2006).
[67] Texas Health and Human Services Commission, "Raising Texas: The Texas Early Childhood Comprehensive Systems Plan," p. 21.

Adverse Childhood Experiences (ACE) Study

Many adults who are diagnosed with mental health problems can trace their symptoms back to childhood, thus suggesting that perhaps prevention and early intervention can improve not only mental but physical health outcomes for children, too. The ongoing Adverse Childhood Experience (ACE) study involving 18,000 adults in San Diego, California provides evidence of how childhood abuse and common household dysfunction can lead to health risk behaviors such as smoking, becoming obese, suicide, and drug abuse. These risky behaviors have long-term consequences far beyond mental illness, particularly for chronic disease, disability, and social problems. The authors conclude that adverse childhood experiences determine the likelihood of the ten most common causes of death in the United States and do so decades before these problems (heart disease, cancer, chronic lung disease) manifest in the primary care setting. The study's conclusions also draw a clear connection between physical and mental health and firmly support approaching mental illness as a public health problem.[68]

Children's Mental Health and State Agencies

The shorter-term impact of behavioral health problems among children and their parents also produces significant and wide-ranging costs. Failure to invest time and resources into children's mental health may affect the foster care, health care, and education systems.[69] For example:

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[68] The Adverse Childhood Experiences Study, *Turning Gold Into Lead.* Available: http://www.acestudy.org/docs/GoldintoLead.pdf. Accessed: August 2, 2006.
[69] Texas Mental Health Transformation: Assessment of Needs and Resources, *Chapter 3: Transformation Drivers,* p. 16.

- 75 percent of children placed in foster care have parents with behavioral health problems;
- 75 percent of youth in the juvenile justice system have behavioral health problems;
- 30 percent of youth in the juvenile justice system will end up in the adult justice system;
- 46 percent of all ER visits have behavioral health issues as a basis or contributing factor;
- 30 percent of all truancy is related to behavioral health problems.[70]

A popular model among some stakeholders is Systems of Care (SOC). SOC is a child-centered, family-focused, and family-driven approach to children's mental health. The SOC model is community-based, with an emphasis on cultural competence and responsiveness.[71] In 1999, Senate Bill 1234 authorized the creation of six Texas Integrated Funding Initiatives (TIFI) sites to develop SOC programs in local communities.[72] Partnerships and coordination between local resources are central to the success of the SOC model, and community partners often include school districts, the child welfare system, health and human services agencies, the local mental health authority, and the juvenile justice system.[73] Significant savings, positive clinical and

[70] Texas Department of State Health Services, *The Texas Approach to Transformation,* PowerPoint Presentation, Austin, Texas.
[71] SAMHSA's National Mental Health Information Center, *Family Guide of Systems of Care for Children with Mental Health Needs.* Available: http://mentalhealth.samhsa.gov/publications/allpubs/Ca-0029/default.asp. Accessed: August 14, 2006.
[72] Texas Government Code, Section 531.251.
[73] The Children's Partnership, *Who We Are.* Available: http://www.childrenspartnership.com/index2.html. Accessed: October 1, 2006.

behavioral outcomes, and increased community capacity can now be documented in all of TIFI sites.[74] Expansion of the SOC model may lead to significant return on investment, and also increase the positive economic and treatment outcomes for the children and families who receive SOC services.

The Mental Health Workforce

Workforce Supply

While physical health conditions are typically diagnosed and treated by physicians, advanced practice nurses, and physician assistants, the mental health and substance abuse workforce consists of psychiatrists, psychologists, social workers, marriage and family therapists, other specialty or primary care physicians, psychiatric nurses, psychosocial rehabilitation therapists, and a variety of counselors.[75] Supply ratios in Texas have decreased for virtually all of these, which affects access to care for everyone, not just those in the public system.

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[74] Texas Health and Human Services Commission, *Report to the Governor and 79th Legislature Systems of Care for Children with Severe Emotional Disturbances and their Families.* Available: http://www.hhsc.state.tx.us/pubs/05_TIFI/AppE.html. Accessed: October 1, 2006.

[75] Mary Jane England and Ann E. K. Page, "A Healthy Mind for a Healthy Population," *Issues in Science and Technology* (Summer 2006), pp.29-38.

Supply Ratios for Specific Mental Health Providers in Texas (1985-2005)

	1985	1990	1995	1999	2000	2001	2002	***2005***
Psychiatrists	6.2	6.8	6.5		6.2			5.6
Child Psychiatrists								2.9
Social Workers				73.9		71.6		68.2
Licensed Professional Counselors (LPCs)						48.5		47.4
Licensed Chemical Dependency Counselors (LCDCs)							22.3	18.2
Marriage and Family Therapists						14.7		12.1
Psychiatric Nurses		31.0			25.0			20.0
Psychologists				24.8				24.2

Adapted from Health Professions Resource Center, *Highlights of the Supply of Mental Health Professionals in Texas*, (February 2006).

This shortage is particularly acute for both general and child psychiatrists. In 2005, there were 1,298 general psychiatrists in Texas, and 190 child psychiatrists.[76] While the number of psychiatrists has increased from 1,133 in 1985 to 1,298 in 2005, the supply

[76] *Ibid*., p. 2.

ratio - the numbers of providers per 100,000 people - for psychiatrists have decreased from a high of 6.8 in 1990 to 5.6 in 2005.[77]

A contributing factor to this shortage is Texas' reliance on non-Texas medical schools for psychiatrists, along with all other physician specialties. In 2005, less than half (47.8 percent) of Texas' psychiatrists were graduates of Texas medical schools. The remaining 52.2 percent were recruited from other states, or foreign medical schools (23.3 and 29.0 percent, respectively).[78] However, the nation as a whole is experiencing a growing shortage of mental health professionals.[79] This national trend makes Texas' reliance on other states for its own workforce, psychiatrists in particular, more problematic.

Workforce Distribution

In addition to the overall supply shortage of mental health professionals, their unequal distribution across Texas is a barrier to access for people living in the rural, West Texas, South Texas, and Panhandle areas of the state. In September of 2005, 188 (74 percent) of Texas counties were designated by the U.S. Department of Health and Human Services as Health Professional Shortage Areas (HPSAs).[80] Most psychiatrists are located along the I-35 corridor from Bexar County to Dallas County, with 181 counties having no psychiatrists at all.[81] Because of low reimbursement rates, many psychiatrists choose to practice in areas where patients can pay out of pocket, which are primarily urban and

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[77] *Ibid.*
[78] *Ibid.*
[79] Michelle Herman, "Child Psychiatrist Shortage Looms," *National Conference on State Legislatures Legisbrief,* Vol. 14, No. 17 (March 2006), pp. 1-2.
[80] *Ibid.,* p. 1.
[81] Health Professions Resource Center, *Highlights of the Supply of Mental Health Professionals in Texas,* (February 2006).

wealthy.[82] Geographic distribution is similar for psychologists, social workers, licensed professional counselors, licensed chemical dependency counselors, and psychiatric nurses, in that rural and border counties typically have a lower supply ratio of these mental health professionals than urban and non-border areas.

There are several initiatives that may help alleviate the severe shortage, and unequal distribution, of the mental health workforce. These include integrated care programs such as the chronic care model for service provision, and the "Grow Your Own" approach to increase the workforce supply.

The Integrated Care Model

The integrated care approach to treatment developed, in part, because of the growing reliance on primary care physicians to address the mental health needs of their patients.[83] The ACE study illustrates the link between physical and mental health, and increasing the public's awareness of this relationship is a goal of the President's New Freedom Commission.[84] A significant barrier to treatment for mental illness is stigma, and people may be more willing to discuss their mental health concerns to a primary care physician, rather than seek out a psychiatrist or other mental health professional.[85]

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[82] Michelle Herman, "Child Psychiatrist Shortage Looms," *National Conference on State Legislatures Legisbrief,* vol. 14, no. 17 (March 2006), pp. 1-2.
[83] The Hogg Foundation for Mental Health, *Integrated Health Care Initiative.* Available: http://www.hogg.utexas.edu/Pages/IHC.html#what2. Accessed. October 25, 2006.
[84] The President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America.* Available: http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf. Accessed: June 2, 2006. p. 15.
[85] *Ibid.*

It is useful to think of integration as a continuum between physical health and mental health, and individual programs may look very different from each other.[86] For example, a primary care physician may simply refer a patient to a mental health provider in the same community. The opposite end of the spectrum would be a co-located, collaborative approach where a primary care physician and a mental health provider communicate regularly, and where the consumer follows a single treatment plan.[87]

A collaborative model may have several components including a mental health assessment tool, a clinical care manager, a patient registry, and the availability of psychiatric consultation.[88] This model may also be carried out using telemedicine, a useful technology that can address the workforce shortage and distribution in rural areas of Texas. It would be ideal for all consumers of mental health services to have face-to-face time with a psychiatrist or other specialized mental health providers as needed. However, due to the current challenges facing Texas with regard to the mental health workforce, the collaborative care model does have documentation of cost-effectiveness and positive clinical outcomes.

A 2004 Department of Veterans Affairs study of an integrated, collaborative care program found that within one year of implementation, the rate of referrals to specialty mental health care professionals dropped from 38 percent to 14 percent.[89] This reduction

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[86] Jennifer Deegan and Becky Pastner, Integrated Mental Health Care, Policy Research Project, LBJ School of Public Affairs (August 2006).
[87] *Ibid.*
[88] The Hogg Foundation for Mental Health, Integrated Health Care Initiative. Available: http://www.hogg.utexas.edu/Pages/IHC.html#what2. Accessed. October 25, 2006.
[89] Bradford L. Felker, M.D., Robert F. Barnes, M.D., et al, "Preliminary Outcomes From an Integrated Mental Health Primary Care Team," Psychiatric Services, Vol. 55 (April 2004), pp. 442-444.

suggests that the multi-disciplinary team of primary care and mental health care providers were able to rapidly evaluate and stabilize patients with a wide range of psychiatric disorders before their symptoms reached a point where more specialized, intensive care was needed. As with any model, there are drawbacks associated with integrated care, particularly when related to the type of mental health workers operating in the primary care setting. Some of these include the "variability in the expertise of counselors and in their recommended treatment, lack of counselor accountability, lack of standardization in treatment methods, and communication breakdown between the primary care and mental health counselor."[90]

The "Grow Your Own" Initiative

Texas is not the only state experiencing a shortage in its mental health workforce, and Alaska has a state program designed to address the difficulties of recruitment and retention in its rural areas. In most areas of Alaska, available mental health services are provided by paraprofessionals, and not by degree-level or credentialed employees. Furthermore, there was no "educational pathway" beyond the paraprofessional level that would train local people to fill the professional provider role.[91]

In response to a growing problem of substance abuse among Alaskans, the University of Alaska Fairbanks created a model to decrease the "revolving door" of behavioral health professionals and to "grow their own" workforce beyond the paraprofessional level. The

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[90] Jennifer Deegan and Becky Pastner, Integrated Mental Health Care, Policy Research Project, LBJ School of Public Affairs (August 2006).

[91] The University of Alaska, *Alaska's Behavioral Health Workforce Initiative.* Available: http://www.alaska.edu/health/downloads/BHP%20Init%20Final.pdf. Accessed: October 23, 2006.

model, referred to as ABC for 1) Added or accelerated access to education and training, 2) Blended delivery of modalities, approaches, and teachers, and 3) a Community or Cohort of adult learners.[92] Over a two-year period, students who may have a G.E.D. or high school diploma can enroll in a specialized curriculum taught in a traditional academic setting. When complete, there is encouragement for the two-year certificate holders to pursue a formal university education.[93]

Recommendations

1. **Request that the Mental Health Transformation Work Group (TWG) provide policy recommendations and report on their ongoing efforts to the Legislature every two years.**

   Rationale: Access to input from the myriad of stakeholders represented on the TWG is key to long-term improvements in the mental health system. The 2008 report should also include recommendations for standardized definitions, training and contracting requirements for behavioral health services.

2. **Direct the TWG to develop common metrics and outcome measures for behavioral health interventions that can be applied by all state agencies that provide such services.**

[92] Presentation by Larry N. Roberts of the University of Alaska Fairbanks at the Innovations in Mental Health Workforce Development. February 14, 2006. (Austin, Texas).
[93] *Ibid.*

Rationale: In order to assess effectiveness of programs across the various agencies that provide them, common measures are needed.

3. **Direct the TWG to develop interagency behavioral health data sharing protocols with the focus of improving coordination of care for individuals who receive services from multiple agencies.**

Rationale: As described in this report, many recipients of behavioral health services obtain services from multiple agencies. In order to make that care effective and efficient, information about mental health consumers should be shared across these agencies.

4. **Early intervention and recovery should be the policy priority for mental health services.**

Rationale: Early intervention and a focus on recovery are key to ensuring that the state mental health system uses resources effectively and efficiently.

5. **Add the Texas Department of Housing and Community Affairs to TCOOMMI advisory agencies.**

Rationale: TCOOMMI attempts to address housing - a need critical for mental health recovery - for offenders when they are in the community, yet the Texas Department of Housing and Community Affairs is not explicitly involved.

6. **Require TCOOMMI to report to the Legislature about the prevalence of mental illness in the criminal justice system as a whole.**

Rationale: Currently, TCOOMMI has no authority over the local MHMR centers and cannot require them to report to the state about the findings of the cross-referencing between the criminal justice system and DSHS. If TCOOMMI is given the mandate to report to the Legislature on prevalence, it can then get the needed information from the MHMR centers.

7. **Monitor the progress and outcome of negotiated rulemaking for the "provider of last resort" requirement of local MHMR centers.**

Rationale: The rulemaking process will be completed in December 2006, and legislation may need to be considered to align the statute with the outcome of this process.

8. **Encourage collaboration between mental health care providers and primary care physicians in the primary care setting.**

Rationale: Integrated care models address the problematic "parallel" systems of mental health and physical health. These models have a following with both mental health and primary care providers, and have been demonstrated to increase access to care and improve clinical outcomes.

9. **Create a fund within DSHS to help offset the cost of telemedicine technology in rural areas.**

Rationale: Low patient volume and concerns about maintenance costs see to discourage rural communities from investing in this needed technology. Access to assistance may help communities make this choice.

10. **Consider piloting a "Grow Your Own" initiative in a rural college/university town to establish a professional base of mental health providers.**

Rationale: Texas is facing critical workforce shortages for virtually all of the mental health workforce. The rural areas are hit harder than urban areas due in part to difficulty in recruiting social workers, counselors, psychologists, and other mental health workers from the rest of the state.

11. **Fund the exceptional item request from DSHS for $82.3 million to fund Crisis Redesign.**

Rationale: Crisis Redesign is a DSHS effort to provide services for people with mental illness who have reached a level of crisis and are a danger to themselves or others. There are many components, but essentially it is a state-wide, coordinated effort to prevent people from ending up in jail or traveling long distances for admission into a state hospital.

12. Require all MHMR Centers in Texas to use a standard method for maintaining a waiting list so the state can better assess local and statewide need for services.

Rationale: It is apparent that centers currently use different reporting methods, with some not reporting at all. Reports should also include the amount of time an individual is on the waiting list.

13. Consider the expansion of Systems of Care wraparound services.

Rationale: The Systems of Care model is popular among mental health consumers and advocates, and data supports the cost-effectiveness and positive clinical outcomes of these programs.

Charge 2: Medicaid Reform

Monitor state and federal Medicaid reform proposals, including their impact on the Medicaid program in Texas, as well as cost-containment measures in other states, and make recommendations for legislative action, as appropriate.

Background

Medicaid is funded by both the state and federal government and administered by the Texas Health and Human Services Commission (HHSC). Medicaid pays for healthcare services for low income families, non-disabled children, relative caretakers of dependent children, pregnant women, elderly and people with disabilities. Statistics indicate that 25.1 percent or 5.6 million of Texans are without health insurance, which is the highest in the nation. During the year, 8.5 million Texans will go without health insurance.[1] Texas Medicaid enrollment has increased by one million people over the past five years.[2] In respect to those Texans provided with Medicaid, two-thirds are children and one-third consists of elderly and individuals with disabilities.[3] With the increase of Medicaid enrollment and state costs, Medicaid reform has taken precedence in the legislative arena.

Recent Legislation

In recent years, Texas has taken many steps to reform Medicaid through the implementation of various programs. During the 79th Legislative Session, Texas focused

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[1] Task Force for Access to Health Care in Texas, *Code Red: The Critical Condition of Health in Texas*. Available: http://www.coderedtexas.org/files/code_red_synopsis.pdf. Accessed: November 13. 2006.
[2] Texas Medical Association, *Federal Medicaid Reform.* Available: http://www.texmed.org/Template.aspx?id=3727. Accessed: November 10, 2006.
[3] *Ibid.*

on administrative streamlining and expanding access by passing Senate Bill 1188, which enacted recommendations of the Governor's Task Force on Medicaid reform, the Senate Committee on Health and Human Services, and other measures.[4] Some additional reform initiatives included Riders 60 and 61; Women's Health Program (WHP); CHIP Perinatal; and Medicaid Buy-In programs.[5]

Senate Bill 1188

Senate Bill 1188 set in motion more than 80 projects intended to improve the Texas Medicaid Program. SB 1188 seeks to improve health outcomes and achieve cost savings by optimizing Medicaid financing, improving data collection and analysis, alleviating administrative burdens for providers, improving case management systems for clients, enhancing quality, reducing inappropriate utilization of hospital emergency rooms, and coordinating educational outreach about the program for both clients and providers. Two projects underway include a case management optimization study and development of a comprehensive plan to reduce emergency room use.[6]

Currently, the Health and Human Services Commission is pursuing a contract with an outside vendor to assist in an optimization analysis of its case management system. The contractor's reports will include: "an analysis of current case management, national best

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[4] Texas Health and Human Services Committee, *Interim Report to the 79th Legislature* (December 2004), Available: http://www.senate.state.tx.us/75r/senate/commit/c610/downloads/rpt_c610_dec2004.pdf. Accessed: November 17, 2006.

[5] Texas Senate Health and Human Services Committee, Testimony of the Texas Health and Human Services Commission (Austin, Tex., September 19, 2006)

[6] Texas Health and Human Services Commission, *Report on Senate Bill 1188: 79th Legislature, Regular Session* (December 1, 2005). Available: http://www.hhsc.state.tx.us/news/presentations/SB_1188_Report.pdf. Accessed: November 10, 2006.

practices in case management, waiver feasibility, recommendations for case management optimization, and stakeholder involvement."[7] SB 1188 encourages appropriate emergency room utilization, improved data analysis, and streamlining of the system's administrative processes.[8]

The Fiscal Year 2004 data analysis indicates that of Medicaid non-emergency visits, more than 1.6 million were emergency department visits, which serve more than 880,000 clients.[9] Via SB 1 (79R) Article II, HHSC Rider 55, a Medicaid Quality Initiative Pilot Project will be created to lower inappropriate use of emergency departments, which is targeted to begin in January 2007. In addition, the program plans to instill public awareness, monitor case management, and inform the public of the availability of alternative health care providers and settings.[10]

Riders 60 and 61

Rider 60 of the Health and Human Services Commission's bill pattern in SB 1 (79R) directed the Commission to convene a workgroup to aid the Executive Commissioner in considering and recommending alternative hospital reimbursement rate methodologies. These recommendations shall include: cost inflators, which would cut down on medical utilization and inflation, rebasing of the rates, such as Diagnosis Related Groupings

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[7] Texas Senate Health and Human Services Committee, Testimony of the Texas Health and Human Services Commission (Austin, Tex., September 19, 2006)
[8] Texas Health and Human Services Commission, *Major Medicaid Legislation 79th Texas Legislature.* Available: http://www.hhsc.state.tx.us/news/meetings/past/2005/Council/HealthServices_062405.pdf. Accessed: October 6, 2006.
[9] Texas Senate Health and Human Services Committee, Testimony of the Texas Health and Human Services Commission (Austin, Tex., September 19, 2006)
[10] *Ibid.*

(DRGs) rates per procedure, and other alternatives, such as waivers that would combine Disproportionate Share Hospital (DSH), Graduate Medical Education (GME) and Upper Payment Limit (UPL) funds.[11] Rider 60 also allows for rewards and incentives for those hospitals that are efficient, provide services to Medicaid clients, and control medical costs.[12]

The impetus for Rider 60 was rooted in significant discussion during the 79th Legislature regarding the funding of hospitals and hospital-related services in Texas and links to Medicaid resources. The continued expansion of Intergovernmental Transfers (IGTs), such as UPL and DSH, has made hospital funding very complex. The prospect of the federal government reducing IGTs as part of deficit reduction only magnifies the seriousness of this situation. There is great interest in developing a hospital financing system that is simple, stable, and transparent in its costs and charges.

Currently, hospital expenditures represent over 62 percent of Medicaid Acute Care Expenditures.[13] Further, approximately 42 percent of state funding for hospital providers is through IGTs. [14] To address some of these issues, the Health and Human Services Commission has issued recommendations pursuant to Rider 60. They include: moving to

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[11] Texas Health and Human Services Commission, *Presentation to the Senate Finance Committee: Uncompensated Care and Medical Hospital Reimbursement* (October 10, 2006). Available: http://www.hhsc.state.tx.us/news/presentations/SenateFinanceCommittee101006.ppt. Accessed: November 7, 2006.

[12] *Ibid.*

[13] Senate Finance Committee, Testimony of the Texas Health and Human Service Commission, p. 16. (Austin, TX., September 10, 2006)

[14] *Ibid.,* p. 16.

a regional standard dollar amount for reimbursement, capping administrative and capital costs, rebasing hospital rates, and raising hospital reimbursement rates.[15]

Rider 61 of the Health and Human Services Commission's bill pattern in SB 1 (79R) directed the Commission to "conduct a study of the components and assumptions used to calculate Texas hospitals' uncompensated care amounts." The rider also requires a report to the Legislature with recommendations for standardizing hospitals' uncompensated care amounts.[16] Uncompensated care is reported by hospitals based on charges with no consistent link back to costs. Given that uncompensated care is a major component of many health reimbursement methodologies and totaled approximately $9.2 billion in charges in 2004, there is a need for a standard method of determining true cost amounts.[17] In its report to the Senate Finance Committee, the Commission indicated that uncompensated care should be the sum of all bad debt and charity care after being reduced to cost, and after patient specific and non-specific funding has been accounted.[18]

Women's Health Program (WHP)

The Women's Health Program, passed as Senate Bill 747, was created to expand health services to low-income women by January 1, 2007. The Health and Human Services Commission will create a five year Medicaid demonstration project to expand access to

[15] *Ibid.,* pp. 24 - 28.
[16] *Ibid.,* p. 3.
[17] *Ibid*., p. 6. While uncompensated charges totaled $9.2 billion in 2004, HHSC estimated that actual costs were between $443 million and $2.3 billion.
[18] *Ibid*., p. 10.

preventive health and family planning services for women 18-44 years of age.[19] Services include comprehensive health history and evaluations; physical exams; health screenings for diabetes, sexually transmitted diseases, high blood pressure, cholesterol, tuberculosis, breast and cervical cancers; family planning services and non-emergency contraception.[20] Rider 71 specified that monies used in the demonstration project may not be used to provide abortion services.[21] The program is expected to bring $49.6 million in savings by the end of FY 2008 and an expansion of women's health services.[22]

Children's Health Insurance Program (CHIP) Perinatal

The CHIP Perinatal program renders services related to labor and delivery, in which CHIP Perinate newborns will have the same benefits as regular CHIP members. The program will be implemented in January 2007. Individuals who qualify will be eligible for 12 months of continuous coverage. This program allows the state to use CHIP dollars for services previously provided by Medicaid, which means the state is able to obtain a better federal matching rate.[23]

Medicaid Buy-In

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[19] Texas Health and Human Services Commission, *Major Medicaid Legislation 79th Texas Legislature.* Available: http://www.hhsc.state.tx.us/news/meetings/past/2005/Council/HealthServices_062405.pdf. Accessed: October 6, 2006.

[20] Texas Senate Health and Human Services Committee, Testimony of the Texas Health and Human Services Commission (Austin, Tex., September 19, 2006)

[21] Texas Health and Human Services Commission, *Major Medicaid Legislation 79th Texas Legislature.* Available: http://www.hhsc.state.tx.us/news/meetings/past/2005/Council/HealthServices_062405.pdf. Accessed: October 6, 2006.

[22] Legislative Budget Board, 79th Legislature Text of Conference Committee Report Senate Bill No. 1, Regular Session (General Appropriations Act) 2005, Available: http://www.lbb.state.tx.us/Bill_79/8_FSU/79-8_FSU_0905.pdf. Accessed: November 17, 2006.

[23] Texas Senate Health and Human Services Committee, Testimony of the Texas Health and Human Services Commission (Austin, Tex., September 19, 2006)

Medicaid Buy-In, established by Senate Bill 566, allows for expanded access to Medicaid services. Medicaid Buy-In allows individuals who are disabled and working, of any age, to receive Medicaid by paying a monthly premium.[24] Eligibility requires a net income at or below 250 percent of the federal poverty level (approximately $24,000 for a family of one) and enrollees are required to participate in cost sharing."[25] This legislation provides an incentive for disabled persons who can work to return to work since they can now retain their Medicaid benefits.

The Deficit Reduction Act

Summary of the Deficit Reduction Act

Although the Deficit Reduction Act (DRA) involves many areas of federal law, our focus will pertain to the provisions on Medicaid. The Deficit Reduction Act will lead to a reduction in federal spending of $39 billion between 2006 and 2010.[26] Medicaid reductions in direct spending are largely in five major categories: prescription drugs; asset transfer changes for long term care eligibility; fraud, waste, and abuse; cost sharing and flexibility; and state financing.[27] Proportionally, the largest amount of savings nationally are in cost-sharing and benefit flexibility, prescription drugs, and asset changes for long term care eligibility.[28]

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[24] *Ibid.*

[25] Texas Health and Human Services Commission, *Major Medicaid Legislation 79th Texas Legislature.* Available: http://www.hhsc.state.tx.us/news/meetings/past/2005/Council/HealthServices_062405.pdf. Accessed: October 6, 2006.

[26] Congressional Budget Office Cost Estimate: S 1932 Deficit Reduction Act of 2005. Available at http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf: (Washington DC, January 27, 2006).

[27] Texas Health and Human Services Commission: Deficit Reduction Act Summary. Available: http://www.hhsc.state.tx.us/news/meetings/past/2006/Council/032406_3f.pdf.

[28] Congressional Budget Office Cost Estimate: S 1932 - Deficit Reduction Act of 2005. Available at http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf: (Washington DC, January 27, 2006).

Required Medicaid Provisions of the Deficit Reduction Act

Pharmacy

Pharmacy provisions involve setting the Upper Payment Limit for generic drugs at 250 percent of the average manufacturing price. In addition, the DRA allows for physician administered rebates for single source and generic drugs, inclusion of authorized generics in best price calculations, and inclusion of children's hospitals in the category of entities eligible for lower price drugs. [29]

Long Term Care

Long term care provisions of the DRA are intended to reduce the dependence on Medicaid for funding for long term care. These provisions also lengthen the look back period for asset transfers and change the start date for asset transfer penalties. Specifically, the asset transfers look back period changed from three to five years, and the penalty period starts on the Medicaid eligibility date. In regards to home equity, individuals with equity over $500,000 are ineligible for Medicaid nursing or long term care services.[30] States may increase the equity limit, but may not exceed $750,000.[31]

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[29] Texas Health and Human Services Commission: Deficit Reduction Act Summary. Available: http://www.hhsc.state.tx.us/news/meetings/past/2006/Council/032406_3f.pdf.
[30] *Ibid. This provision is waived if a spouse, a child under 21 or child with disabilities resides in the home.*
[31] Disability Quality Collaboration, *The Deficit Reduction Act of 2005 P. L. 109-171*. Available: http://www.thearc.org/ga/DeficitReductionActof20053.23.06.doc. Accessed: November 10, 2006.

Current Texas Medicaid eligibility requirements for long term care exempt an individual's home equity from consideration. Texas has not increased its equity limits and maintains the Deficit Reduction Act limit of $500,000.[32]

Fraud, Waste, and Abuse

The DRA requires states to provide any entity receiving $5 million or more in Medicaid payments must:

- Establish written policies and procedures for training all employees, contractors, and agents about the federal False Claims Act, any state laws on civil and criminal penalties for false claims, and whistleblower protections,
- Include in such materials the entity's policies for detecting and preventing fraud, waste and abuse, and
- Include in employee handbooks discussion of these items.

In addition, the DRA prohibits restocking and double billing of prescription drugs.[33] The DRA also establishes a Federal Medicaid Integrity Program, which is run by the Centers for Medicare & Medicaid Services (CMS) and works with states to identify and eliminate Medicaid fraud and abuse.[34] The DRA also expands the definition of third party payor to extend liability to entities that are not included in legal liability provisions, such as "self-

[32] Texas Senate Health and Human Services Committee, Testimony of the Texas Health and Human Services Commission (Austin, Tex., September 19, 2006).
[33] Texas Health and Human Services Commission: Deficit Reduction Act Summary. Available: http://www.hhsc.state.tx.us/news/meetings/past/2006/Council/032406_3f.pdf.
[34] Hinkley, Allen, Snyder, LLP: *Medicaid Fraud and Abuse Provisions in Deficit Reduction Act of 2005*. Available: http://www.haslaw.com/publications/Client%20Update-7-2006-RZiegler.pdf. Accessed: November 10, 2006.

insured plans, pharmacy benefit managers and other entities responsible for paying a claim." [35] Under the DRA, states will now require Medicaid applicants to document their United States citizenship or nationality at the time of application.[36] Previously, Texas did not require Medicaid applicants to provide documentary proof of citizenship. Therefore, new applicants, as well as those seeking renewal of Medicaid benefits, must now provide proof of citizenship or nationality. [37]

State Financing

The DRA prohibits states from taxing Medicaid managed care organizations at a higher rate than commercial or other managed care organizations.[38] The DRA also includes a Katrina hold harmless provision to protect Texas' Federal Medical Assistance Percentage (FMAP) amount. Because of the FMAP formula and data collection timelines, inclusion of Katrina evacuees in the formula will otherwise reduce the FMAP and increase Texas' share of Medicaid costs.[39] The DRA also allows for an extension of transitional Medicaid through December 2006, and addresses payment for emergency services provided by non-contracted providers to HMO clients.[40]

Family Opportunity Provision Act

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[35] *Ibid.*
[36] 42 U.S.C. 1396b(x)(3).
[37] Laura D. Hermer, "Legislative Briefing: Recent Federal Changes to Medicaid," University of Houston Health Law and Policy Institute. (June 1, 2006).
[38] Texas Health and Human Services Commission - Internal Memo; Deficit Reduction Act: Summary and Description and Preliminary Impact Analysis (3/13/06).
[39] *Ibid.*
[40] Texas Health and Human Services Commission: Deficit Reduction Act Summary. Available: http://www.hhsc.state.tx.us/news/meetings/past/2006/Council/032406_3f.pdf.

This legislation makes "eligibility for individuals under 21 effective on the latter of the date the application was filed or the date Supplemental Security Income (SSI) eligibility was granted."[41]

Optional Medicaid Provisions

Waste, Fraud and Abuse

The DRA encourages enactment of state False Claims Acts by creating an incentive for those states that duplicate federal law. Specifically, states can receive 10 percent more of certain recoveries if state law reflects federal law.[42]

Long Term Care

The Medicaid ineligibility limit for home equity can be increased up to $750,000. The DRA promotes the use of long term care partnerships to support the private purchase of long term care insurance. In addition, the DRA has provided for expanded access to home and community based services (HCBS). The DRA would also allow states to include personal assistance or "cash and counseling services" as state plan services for recipients of Medicaid "home and community based" services.[43]

Flexibility in Cost-Sharing and Benefits

[41] Texas Health and Human Services Commission - Internal Memo; Deficit Reduction Act: Summary and Description and Preliminary Impact Analysis (3/13/06).
[42] Texas Health and Human Services Commission: Deficit Reduction Act Summary. Available: http://www.hhsc.state.tx.us/news/meetings/past/2006/Council/032406_3f.pdf.
[43] Texas Health and Human Services Commission - Internal Memo; Deficit Reduction Act: Summary and Description and Preliminary Impact Analysis (3/13/06).

The DRA allows states greater flexibility to require premiums and cost-sharing through state plan amendments, and also allows states to make payment of premiums a condition of Medicaid eligibility and of cost-sharing as a condition for receiving services. The law exempts or restricts premiums and cost-sharing for individuals including: children under 18 in mandatory coverage groups, individuals receiving foster care or adoption care services, individuals in institutions or in hospice, and services provided to pregnant women if the service relates to the pregnancy. The law also prohibits cost-sharing for preventive services and EPSDT services to children. The DRA extends cost-sharing to non-emergency visits to emergency rooms under certain conditions. In Texas, only a small number of current Medicaid clients could be required to pay premiums. The DRA also allows states to provide a benchmark benefit package to certain Medicaid recipients. In Texas, a small group of Medicaid recipients could be provided the basic benefit package. The population eligible for benchmark benefit packages include individuals who are not blind, disabled, medically frail, institutionalized or TANF-level recipients and pregnant women with incomes between 133 percent of the FPL and 185 percent of the FPL. While children could be provided a basic benefit package, federal law still requires that they still be provided with access to the full range of EPSDT services.[44]

State Financing

In 2007 and 2008, Medicaid Transformation Grants will provide up to $75 million nationally for states to encourage innovative approaches, improve efficiency and increase effectiveness of their Medicaid programs. Innovative approaches include: drug

[44] Texas Senate Health and Human Services Committee, Testimony of the Texas Health and Human Services Commission (Austin, Tex., September 19, 2006).

utilization programs, reduction of patient error rates through electronic tools and improvement of access to physician services through university-based hospital clinic systems. Texas has submitted an application for transformation funds for various projects including foster care health information technology enhancements; three-share seed grants; long term care financing and insurance and planning awareness, and payment error rate tracking and reduction. The DRA allows for state options to establish non-emergency transportation programs and expansion of abstinence education.[45] The DRA also allows for Health Opportunity Accounts, which require states involved in the demonstration program to financially cover the same benefits normally offered under Medicaid. Texas has the option to seek a waiver to start a Health Opportunity Account program.[46]

Family Opportunity Act Provisions

The Family Opportunity Act provisions include grants for a program called "Money Follows the Person." For Texas, in relation to the Money Follows the Person grant, the enhanced rate would "result in an increase in the federal match from 60 percent to 80 percent of eligible client costs for one year."[47] Texas has an existing Money Follows the Person program and is considering additional program options made by this legislation. Another option is expanded coverage for certain children up to age 18 who meet SSI disability criteria and families with incomes up to 300 percent of the FPL ($60,000 for a

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[45] Texas Health and Human Services Commission: Deficit Reduction Act Summary. Available: http://www.hhsc.state.tx.us/news/meetings/past/2006/Council/032406_3f.pdf.
[46] Laura D. Hermer, "Legislative Briefing: Recent Federal Changes to Medicaid," University of Houston Health Law and Policy Institute. (June 1, 2006).
[47] Texas Senate Health and Human Services Committee, Testimony of the Texas Health and Human Services Commission (Austin, Tex., September 19, 2006).

family of four). In addition, if families have coverage under qualified group health plans, parents are required to purchase employer sponsored coverage if the employer pays 50 percent or more of the premium.

DRA Impact on Texas

According to the Texas Health and Human Services Commission, Texas anticipates the major effects of required DRA provisions to include a new maximum amount that states can pay for generic drugs. Asset protection policy changes could result in reduced Medicaid expenditures. The Department of Family and Protective Services is expected to lose Medicaid case management reimbursements due to a redefinition from the federal government on allowable costs and services. [48]

The Deficit Reduction Act is expected to have a significantly different impact on Texas than other states due to factors such as different populations covered, different optional services, differences in use of managed care, among other factors. New cost-sharing options are only allowable for a small amount of individuals in Texas. Some of the federal savings will result from shifting costs to the states. For example, Texas anticipates a significant loss of federal funds for Targeted Case Management.

Medicaid Reform in Other States

Long Term Care

[48] Texas Health and Human Services Commission: Deficit Reduction Act Summary. Available: http://www.hhsc.state.tx.us/news/meetings/past/2006/Council/032406_3f.pdf.

New Hampshire has increased home and community based care options and capacity, created a single-point entry with uniform assessment instrument, and extended the look back period for divestment of assets. [49] The following states have already implemented long term care partnership programs: California, Connecticut, Indiana, and New York.[50]

The majority of purchasers in California, Connecticut, and Indiana had assets in excess of $350,000, and the average person age 55 or over has less than $50,000 in assets.[51] The New York program allows unlimited asset protection for purchasers.[52] For further information, please see the joint charge 2 chapter of this report.

Consumer Responsibility

Florida has initiated a program using Enhanced Benefit Accounts. Under this program, a patient who demonstrates "healthy behavior and wellness activities" will get credits up to $125 per year to purchase certain health-related items at any participating Florida Medicaid pharmacy.[53]

West Virginia has instituted a program that allows for patient responsibility provisions, in which a patient must sign a member agreement that outlines their duties as a responsible patient. These responsibilities include keeping appointments and participating in health

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[49] AARP Public Policy Institute: *Long-Term Care Insurance Partnership Programs.* Available: http://www.aarp.org/research/longtermcare/insurance/fs124_ltc_06.html. Accessed: November 1, 2006.
[50] *Ibid.*
[51] *Ibid.*
[52] *Ibid.*
[53] NGA Center for Best Practices. *Creating Healthy States: Promoting Healthy Living in the Medicaid Program*. (Washington, DC)

improvement programs.[54] They are also promoting healthier living among Medicaid beneficiaries by offering enrollees a benefits package that includes "coverage for tobacco cessation treatment, nutrition education, diabetes care, treatment for chemical dependency, mental health services, cardiac rehabilitation, chiropractic services and dental care."[55] In addition, West Virginia offers a Health Rewards Account, which allows members an opportunity to accrue credit toward health services. They are awarded for making healthy decisions and for proper use of the health care system.[56]

Delivery System

Florida will "develop a risk adjusted premium amount for each enrollee that can be used to either: purchase coverage in a state approved managed care plan or Provider Sponsored Network (PSN); or voluntarily opt out of Medicaid and use dollars to purchase coverage through an employer or individual market."[57] Florida has also initiated a "defined contribution" plan, which is a fixed premium paid to the provider organization per plan member, rather than a "fixed benefit" model under which the provider is reimbursed for the delivery of specific services.[58]

New Mexico has initiated an employer-based public/private partnership program, which allows New Mexico to contract with managed care organizations to provide a new

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[54] Helen Kent Davis, "*Overview of Federal Medicaid Reform Provisions and Emerging State Reform Initiatives,*" Texas Medical Association.
[55] NGA Center for Best Practices. *Creating Healthy States: Promoting Healthy Living in the Medicaid Program*. (Washington, DC)
[56] *Ibid.*
[57] Helen Kent Davis, "*Overview of Federal Medicaid Reform Provisions and Emerging State Reform Initiatives,*" Texas Medical Association.
[58] National Conference of State Legislatures, *Florida Medicaid Reform,* Available: www.ncsl.org/programs/health/flmedicaid.htm. Accessed: October 13, 2006.

insurance product for small businesses to offer their low income workers. Employers and employees pay part of the premium with state and federal funds picking up the remainder of the cost. [59]

Oklahoma has taken reform measures to combat their high uninsured rates. Their program, called O-EPIC, requires employers to contribute 25 percent of the monthly premium, while employees pay up to 15 percent of the premium. Employees also pay applicable deductibles and co-payments. The initiative also includes a Public Product Health Care Plan for self-employed persons, unemployed persons currently seeking work, and workers not eligible to participate or do not have access to an employer's health plan.[60]

Disease Management

Illinois is promoting developmental screening tools to identify areas needing preventive or other health services. The approach of early identification, health promotion, and intervention can improve health outcomes and identify problems before they impact development.[61] Although Texas already has disease management programs for chronic illnesses, such asthma and diabetes, Texas has not enacted programs that focus on childhood development to prevent disease.

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[59] National Conference of State Legislatures, *New Mexico State Coverage Insurance*, Available: www.ncsl.org/programs/health/nmmedicaid.htm. Accessed: October 6, 2006.
[60] National Conference of State Legislatures, *Oklahoma Employer-Employee Partnership for Insurance Coverage (O-EPIC),* Available: www.ncsl.org/programs/health/okmedicaid.htm. Accessed: October 4, 2006.
[61] *Ibid.*

Benefits

Massachusetts is implementing a program involving a "health care connector," which connects individuals and small employers with affordable health insurance. All products sold through the Connector must offer comprehensive benefits, including mental health coverage.[62]

Kentucky's program, KYHealth Choices, provides incentives to beneficiaries who are engaging in healthy behaviors. Funds will be deposited in accounts to offset specific health care-related costs such as co-payments, smoking cessation and weight loss programs.[63]

Idaho's program involves a target specific package of benefits to enrollees. These enrollees are divided into the following groups: children, people with disabilities and dual-eligible beneficiaries. The three target plans include: Benchmark Basic Plan, Enhanced Benchmark Plan, and Coordinated Benchmark Plan.[64] This program uses what is known as "tiered" benefits, which has also been implemented in Kentucky and West Virginia. This program allows for a decrease in liability because the benefit package assignments set the boundaries for state costs.[65]

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[62] Helen Kent Davis, "*Overview of Federal Medicaid Reform Provisions and Emerging State Reform Initiatives,*" Texas Medical Association.
[63] National Conference of State Legislatures*, KY Health Choices,* Available: http://www.ncsl.org/programs/health/kymedicaid.htm, Accessed: October 3, 2006.
[64] National Conference of State Legislatures, *Idaho State Plan Amendment*, Available: http://www.ncsl.org/programs/health/idmedicaid.htm, Accessed: October 3, 2006.
[65] The Kaiser Commission, *Medicaid and the Uninsured: New Developments in Medicaid Coverage: Who Bears Financial Risk and Responsibility,* Available: http://www.kff.org/medicaid/upload/7507.pdf. Accessed: November 17, 2006.

Cost Sharing

South Carolina has initiated a program called "South Carolina Healthy Connections" which requires most classes of Medicaid beneficiaries to purchase their own healthcare or coverage using a defined sum of money deposited into a "personal health account" ("PHA") to be administered by the state.[66] "Beneficiaries would have the option of paying for their healthcare out of their pocket, purchasing qualifying private managed care coverage, participating in 'medical home network,' or opting out of Medicaid altogether by enrolling in employer-sponsored health insurance or purchasing non-qualifying private health insurance."[67]

Eligibility

Massachusetts requires residents to own employer sponsored or private health insurance. If the state determines insurance is unaffordable for an individual, this provision will be waived. Massachusetts also requires employers with 11 or more employees to offer insurance or pay a $295 per employee fee to help subsidize a safety net.[68]

Arkansas is now expanding eligibility to uninsured workers, up to 200 percent of the FPL.[69] The Arkansas Safety Net Benefit Program, a HIFA waiver, enables participating employers with fewer than 500 employees an opportunity to participate in the program,

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[66] Laura D. Hermer, "The Role of Medicaid and the Case of South Carolina's 'Healthy Connections' Proposal" University of Houston Health Law and Policy Institute. (March 2006). Available: http://www.law.uh.edu/healthlaw/perspectives/2006%5C(LH)SouthCarolinaMedicaidFinal.pdf.
[67] *Ibid.*
[68] Helen Kent Davis, "Overview of Federal Medicaid Reform Provisions and Emerging State Reform Initiatives," Texas Medical Association.
[69] National Conference of State Legislatures. Arkansas Safety Net Benefit Program March 2006. Available: http://www.ncsl.org/programs/health/arkmedicaid.htm. Accessed: October 6, 2006.

which will provide limited group health insurance coverage to adults who work for a participating employer.[70] Enrollees are required "to pay a portion of their health care costs, including a monthly premium of up to $15, a $100 deductible, 15 percent coinsurance for all services except for pharmacy services, and a $1,000 out-of-pocket maximum per year."[71]

Recommendations

1. **Create a committee that will recommend incentives, such as tax breaks, to businesses who provide health insurance and long term care insurance for their employees.**

   Rationale: To reward businesses for choosing to offer health insurance and also create incentives for employees to choose their employer's health plan over Medicaid or CHIP. This would move more Medicaid eligible individuals into the private market. This committee should consider incentives that will reach small employers, as certain tax breaks may not affect all businesses.

2. **Increase awareness and education to encourage individuals to purchase long term care insurance.**

   Rationale: By increasing awareness and education, individuals will be more prone to purchase long term care insurance and lessen future reliance on Medicaid. DADS and HHSC should

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[70] *Ibid.*
[71] *Ibid.*

work together to develop materials that would address barriers to purchase, including difficulty of administration and lack of program awareness.

3. **Increase participation in the Health Insurance Premium Programs (HIPP) by improving reimbursement options for participants; requiring targeted information sharing with Medicaid recipients who are able to participate; and including a question on the Medicaid application to determine if the applicant or immediate family members have access to employer-sponsored health insurance.**

Rationale: An individual's enrollment in a private group health plan is considered cost-effective if the expenditures in Medicaid payments are likely to be greater than the cost of paying the premiums and cost- sharing obligations under an employer group health plan for those services. Those who are able to take advantage of this arrangement can maintain coverage while freeing up Medicaid dollars for others.

4. **Create an incentive program for Medicaid recipients to lead healthier lifestyles; pilot in one region to test outcomes.**

Rationale: If Medicaid recipients receive incentives for leading healthy lifestyles, their use of high cost, chronic care Medicaid services will decrease. Disease management and prevention initiatives will lead to less use of Medicaid resources and better health outcomes for recipients.

5. **Direct the HHSC and the Office of the Inspector General to study and implement methods to increase the use of technology to verify coverage and citizenship.**

Rationale: HHSC has an exceptional item to expand the Medicaid integrity pilot as part of the integrated benefits card, and protecting Medicaid from fraud and abuse is paramount so that taxpayer dollars are not wasted, but assisting those who truly need services.

6. **Direct HHSC to develop customized benefit plans to match the needs of the different population groups.**

Rationale: Medicaid covers all clients with the same basic mix of services although some may not be proper for the patient (i.e. prostate exams for children). A variable mix tailored to each group, as was done in the development of Texas CHIP, will help contain costs and focus services on the individual.

7. **Create a Long Term Care Partnership Program.**

Rationale: A Long Term Care Partnership program would reduce Medicaid expenditures by delaying or eliminating the need for individuals to rely on Medicaid to pay for long term care.

8. **Create a "connector" entity within the Texas Department of Insurance (TDI).**

Rationale: To increase consumer access to information about insurance plans. TDI does limited business and consumer outreach and assistance with access to health insurance, but in recent years, it has been a key player in community efforts to provide employer-based insurance options. Creating an office within TDI that is charged with providing an education and awareness "link" for individuals, businesses and providers will fill a void that is costing the state millions in Medicaid and uncompensated care.

9. Explore more transparent and simplified methods of hospital financing.

Rationale: The use of Intergovernmental Transfers (IGTs) for hospital financing has grown to the point where it finances 42 percent of Medicaid hospital reimbursements. Given the complexity of these transactions and their uncertain future with the federal government, the time has come to explore more straightforward and reliable methods of funding.

10. Increase reimbursement rates for physicians.

Rationale: There is a great deal of concern that Texas' current provider reimbursement rates are reducing the quality of and access to care, particularly with specialists and in our non-metropolitan areas. In some cases, providers have not

experienced a rate increase since the early 1990s and they are falling markedly behind Medicare and private health plan reimbursements. This issue is particularly true with certain physician specialties and in some geographical areas. Targeted rate increases would provide a great deal of assistance in recruiting and retaining more providers, especially in critical areas.

11. Consider co-pays for non-emergent emergency room usage.

Rationale: DRA provides flexibility on some co-pay items, but primarily for optional populations of which Texas has few. Co-pays can encourage recipients to make better choices about their care.

12. Consider Health Opportunity Accounts for recipients.

Rationale: The ability for individuals to make purchasing decisions would introduce more of a market-based approach to the system. A certain amount of money could be placed into the account by the state to use for healthcare or wellness programs.

Charge 3: Health Care Workforce

Study and make recommendations relating to filling shortages in the health care workforce and improving medical educational services.

Background

Shortages in Texas

Texans are not strangers to waiting to see health care professionals or having to travel long distances to find needed care. Currently, 46 percent of Texas' 254 counties are designated whole-county Health Professions Shortage Areas (HPSAs) by the federal government.[1] Additionally, 195 counties are or contain Primary Care HPSAs, 142 Dental Care HPSAs and 206 Mental Health HPSAs.[2] 227 counties are either Medically Underserved Areas or contain Medically Underserved Populations.[3] As the Texas population continues to increase, the issue of access to health care professionals is likely only to grow.

There are a number of factors that influence workforce supply. These include: the aging workforce, mal-distribution of health care professionals, salary and benefit issues for providers and working conditions of providers.[4] Certain factors also impact the demand for health care providers, including the aging population, scope of practice changes,

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[1] Diana Smith, "Struggling with Workforce Shortages? Hospitals Use Innovative Ideas to Attract and Retain Staff," *Texas Hospitals*, Vol. 3, No. 2 (March/April 2006), p. 18, 19.
[2] Texas Health Institute. *Health Information Technology: Preparing the Health Care Workforce* (2005).
[3] *Ibid.*
[4] Texas Health Care Policy Council Workforce Partnership Subcommittee, Testimony of the Statewide Health Coordinating Council (Austin, Tex., April 20, 2006).

medical advances, insurance coverage, insurance reimbursements, population growth and the rate of chronic illness.[5] If nothing is changed, these factors will work against each other to drastically increase the ratio between demand and supply.

Physicians

Shortages

Physician shortages are a concern not just in Texas, which ranks 45th in the nation in physicians per 100,000 population,[6] but nationwide.[7] National surveys demonstrate long wait times for cardiologists, dermatologists, orthopedic surgeons and obstetricians.[8] The Council on Graduate Medical Education predicts that there will be a shortage of 96,000 physicians in the U.S. by 2020,[9] which will have a strong impact on access to care throughout the United States. Current shortages are felt largely in rural areas, where only nine percent of U.S. physicians practice even though 17 percent of the population lives in rural areas.[10] Particularly severe are rural shortages of obstetricians and mental health professionals.[11]

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[5] *Ibid.*
[6] Ken Orton, "Supply versus demand," *Texas Medicine* (May 2006), p. 39, 40.
[7] Please note that while supply ratios will be discussed in comparison to national averages in this Chapter, there is no evidence that national averages are ideal supply ratios.
[8] Julie Bell, "Symptoms of a doctor shortage," *The Baltimore Sun* (October 16, 2005). Available: http://www.baltimoresun.com/news/nationworld/bal_te.shortage16oct16,1,1470893.story. Accessed: October 17, 2005.
[9] *Ibid.*
[10] Amy Winterfeld, *Economic Development and Rural Health*. National Conference of State Legislatures (July 2005), p. 3.
[11] *Ibid.*

As the population continues to age, demand for such specialists as endocrinologists, urologists, orthopedists and nephrologists is expected to grow,[12] increasing the extent of the physician shortage. Additionally, the rise in the aging population will lead to an increased need for geriatricians. In 2005, Texas had only 31 physicians with a primary specialty in geriatrics and 256 with a secondary specialty in geriatrics. Texas has only seven geriatric medicine fellowship programs, which were training 15 residents during the 2005-2006 academic year.[13]

Primary care physician supply ratios in Texas have consistently been lower than the United States average, with almost a 10 physician per 100,000 people difference in 2000, and the gap is continuing to widen.[14] In 2005, 27 Texas counties did not have a primary care physician, and 16 counties had only one.[15]

Texas has had some success in increasing its physician supply in the past few years. Since the passage of tort reform legislation in Texas, the state has added more than 3,000 physicians, including 98 new orthopedic surgeons, 90 obstetrician-gynecologists and 24 neurosurgeons, all specialties that are impacted by rising malpractice insurance premium costs.[16]

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[12] Ken Ortolon, supra note 6, p. 41.
[13] Texas Department of State Health Services, Center for Health Statistics, Health Professions Resource Center, *Highlights: The Supply of Primary Care Physicians in Texas - 2005*, Publication No. 25-12420 (August 2006), p. 4.
[14] Statewide Health Coordinating Council, *2007-2008 Texas State Health Plan Update* (draft) (August 2006).
[15] *Ibid.*
[16] Bruce Davidson, "Malpractice reform healing system," *San Antonio Express-News* (February 26, 2006).

In order to address the coming physician shortage, the Council of Graduate Medical Education has recommended that medical schools increase enrollment by 15 percent between 2002 and 2012.[17] This is particularly important in Texas, where capacity in medical schools has remained constant over the past 20 years. This is part of the reason 53 percent of practicing physicians in Texas graduated from medical schools outside the state.[18] Acknowledging the need for larger medical school classes, the Texas A&M College of Medicine has announced plans to increase its class size from 80 to 200 students per graduating year.[19]

Another issue with maintaining the physician workforce in Texas is the size of our graduate medical education program. Research has demonstrated a strong correlation between where a physician completes his graduate medical training and where he will practice. In 2004, 56.9 percent of Texas medical school graduates planned to stay in Texas to complete their training. An additional 38 percent would have preferred to stay in Texas but did not because of the lack of availability of training slots.[20]

Nurses

Background

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[17] Julie Bell, supra note 8.
[18] Center for Health Statistics, *Primary Care Physicians*, supra note 13, p. 1.
[19] April Avison, "Dickey: Facility could aid area," *Bryan-College Station Eagle* (July 2, 2006).
[20] Center for Health Statistics, *Primary Care Physicians*, supra note 13, p. 6.

Possibly the most publicized workforce shortage involves nursing. The current Texas hospital nursing vacancy rate is 12 percent,[21] and the U.S. Bureau of Labor Statistics estimates that the nursing shortfall will reach 1 million by 2020.[22]

Registered Nurses

In 2005, there were 144,602 registered nurses (RNs) practicing in Texas, with 85.8 percent working full-time and 14.2 percent working part-time. Texas had 628.6 RNs per 100,000, which is significantly lower than the national rate of closer to 800 RNs per 100,000.[23]

In 2005, 12,097 qualified applicants were not admitted to initial RN licensure programs based in part on faculty shortages.[24] This means that the influx of new RN graduates is unlikely to address concerns about RNs retiring and leaving the field. This is particularly true in rural areas as the median age for RNs in Texas is 46 years old but is 48 in rural areas.[25]

Licensed Vocational Nurses

Licensed vocational nurses provide supervised nursing care. In 2005, there were 61,886 licensed vocational nurses in active practice in Texas, creating a supply ratio of 269 per 100,000 population. Texas licensed vocational nurse ratios actually exceed the national

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[21] Diana Smith, supra note 1.
[22] National Conference of State Legislatures, *Health People, Strong Communities: Strategies for Improving Rural Health and Strengthening the Local Economy* (November 2005), p. 11.
[23] Statewide Health Coordinating Council, supra note 14.
[24] Texas Senate Health and Human Services Committee, Joint Testimony of the Texas Nurses Association and Texas Hospital Association (Austin, Tex., May 16, 2006).
[25] *Ibid.*

average, but the spread has been decreasing since 1998. Licensed vocational nurses are often relied upon in rural areas where RN shortages are significant.[26]

Advanced Practice Nurses

The term advanced practice nurse includes nurse practitioners, nurse midwives, certified registered nurse anesthetists and clinical nurse specialists.[27]

Nurse practitioners practice under their own authority as nurses and in collaboration with physicians to provide such services as prescribing medications. Texas had 4,066 practicing nurse practitioners in 2005. The highest nurse practitioner supply ratios are in Panhandle and West-Central Texas counties, but the Texas supply ratios of nurse practitioners has been lower than the national average for years.[28]

Certified nurse-midwives provide gynecological and obstetrical care for women during pregnancy, childbirth and the post-partum period. Direct-entry midwives are not RNs but complete a midwifery course and pass a state-approved examination required by the Texas Midwifery Board. Certified nurse-midwives must have RN educational preparation and are regulated by the Texas Board of Nurse Examiners. In 2005, Texas had 244 certified nurse-midwives who were located largely in metropolitan areas of the state. The Texas supply ratio of certified nurse-midwives per 100,000 women of

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[26] Statewide Health Coordinating Council, supra note 14.
[27] *Ibid*
[28] *Ibid*.

childbearing age has been behind the United States average since such information first became available.[29]

Texas had 1,701 certified registered nurse anesthetists in 2005. Their ratio in Texas increased by 30 percent between 1998 and 2005.[30]

Certified nurse specialists in Texas are located largely in metropolitan areas and had a decrease in their ratios by 10 percent between 1998 and 2005. In 2005 there were only 864 certified nurse specialists in Texas.[31]

Dentists

The number of dentists per population size has been dropping in recent years, and the American Dental Association and Health Resources and Services Administration estimate that by 2020 there will be only 53 active dentists per 100,000 people. The peak of dental availability was in 1990 with 60 dentists per 100,000; the law was 50 per 100,000 between 1950 and 1970.[32] In 2005, there were 8,213 dentists practicing in Texas, with a supply ratio of 35.7 per 100,000 people, significantly behind the national average.[33]

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[29] *Ibid*.
[30] *Ibid*.
[31] *Ibid*.
[32] Tara Lubin, "Dental Workforce," *National Conference of State Legislatures Legisbrief*, Vol. 14, No. 18 (March 2006).
[33] Statewide Health Coordinating Council, supra note 14.

Another problem for the dental workforce is the aging of dental school faculty. Currently, 47 percent of dental faculty is at least 50 years old, and 19 percent are 61 years old or older.[34] While it is possible that the next generation of older dentists will choose to enter into teaching, this is not a very stable supply of faculty and shortages could increase as current faculty members retire.

Pharmacists

Background

Since 2002, the number of Texas pharmacists has not grown at the same rate as our population growth. Texas currently ranks 39th among the 50 states with respect to its pharmacist-to-population ratio.[35] Pharmacist access is particularly problematic in rural areas, where more than 13 percent of the Texas population lives, but only 9.6 percent of Texas pharmacists work.[36]

Recently the education requirements for becoming a pharmacist changed to requiring a Doctor of Pharmacy degree, which requires at least six years of education.[37] However, the Texas pipeline has expanded to help meet the need for pharmacists with the addition of the new pharmacy schools in Kingsville and San Antonio, bringing the number of Texas pharmacy schools to six.[38]

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[34] *Ibid.*
[35] Senate Health and Human Services Committee, Testimony of Ryan Roux, Texas Pharmacy Association (Austin, Tex., May 16, 2006).
[36] Texas Department of State Health Services, Center for Health Statistics, Health Professions Resource Center, *Highlights: The Supply of Pharmacists in Texas - 2005*, Publication No. 25-12353 (February 2006), p. 1.
[37] Ryan Roux, supra note 35.
[38] Center for Health Statistics, *Pharmacists*, supra note 36, p. 4.

Mental Health Professionals

Background

Mental health professional shortages exist in a large portion of Texas counties. These shortages limit people's ability to seek appropriate diagnoses and appropriate and timely care.

Psychiatrists

Psychiatrists are the physician-level practitioners in the mental health field. They provide a full range of mental health services, including diagnosis and talk and drug therapies. In 2005, there were 1,298 general psychiatrists and 190 child psychiatrists in Texas, leaving 181 counties without a psychiatrist and 188 counties as Mental Health HPSAs.[39] Psychiatrist shortages are particularly extreme in the rural and border areas, where residents must depend largely on state mental health/mental retardation facilities in order to find needed providers.[40] This shortage is expected to continue to grow as the number of psychiatry residency positions in Texas has remained the same for the past 10 years and the average age of psychiatrists is 52.9, suggesting that many will soon be retiring.[41]

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[39] Texas Department of State Health Services, Center for Health Statistics, Health Professions Resource Center, *Highlights: The Supply of Mental Health Professionals in Texas - 2005*, Publication No. 25-12347 (February 2006), p. 1.
[40] *Ibid*., p. 2.
[41] *Ibid*., p. 2-3.

All 50 states are experiencing child psychiatry shortages.[42] Almost one in five children in the U.S. has a diagnosable mental disorder, but only 20-25 percent of these actually receive treatment.[43] This is due in part to the vast shortage of qualified providers – the projected need for child psychiatrists is 30,000, but only 7,000 are currently practicing.[44] Currently, rural Texas children face the greatest difficulties seeking care, as only five child psychiatrists practice in rural counties.[45]

Psychologists

Psychologists diagnose and treat mental health issues, but they can not prescribe medications in Texas. The Board of Examiners of Psychologists licenses four types of psychological providers - licensed psychologists, provisionally licensed psychologists, licensed specialists in school psychology and licensed psychological associates.[46] Licensed psychologists have doctorate degrees in psychology and are authorized to practice independently. Provisionally licensed psychologists have doctorate degrees but must be supervised. The licensed psychological associate license is a master's degree license, and such practitioners must have their practices supervised. Licensed specialists in school psychology may practice independently in public schools after one year of

[42] Associated Press, "Shortage of child psychiatrist takes nationwide toll," *CNN.com* (April 7, 2006). Available: http://www.cnn.com/2006/HEALTH/04/07/child.psychiatrists.ap/index/html. Viewed: April 17, 2006.
[43] Michelle Herman, "Child Psychiatrist Shortage Looms ," *National Conference of State Legislatures Legisbrief*, Vol. 14, No. 17 (March 2006).
[44] *Ibid*.
[45] Center for Health Statistics, *Mental Health Professionals*, supra note 39, p. 4.
[46] *Ibid*., p. 5.

supervised practice; the license requires completion of a school psychology training program or a master's degree in psychology with relevant course work.[47]

In 2005, there were 3,336 licensed psychologists, 151 provisionally licensed psychologists, 1,162 licensed psychological associates and 2,091 licensed specialists in school psychology; 112 counties did not have a psychologist.[48]

Social Workers

Social workers diagnose and treat mental conditions through therapy.[49] There are four types of social work licenses in Texas: Licensed Clinical Social Workers, Licensed Master Social Workers, Licensed Master Social Workers-Advanced Practitioners and Licensed Baccalaureate Social Workers.[50] In 2005, there were 15,687 social workers in Texas, and 46 counties did not have a social worker.[51]

Licensed Professional Counselors

Licensed professional counselors use counseling, assessment, consulting and referral to help facilitate human development and adjustment throughout the life span.[52] In 2005, there were 10,896 licensed professional counselors, and 54 counties where none were practicing.[53]

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[47] Texas State Board of Psychologists, *How to Become Licensed*. Available: http://www.tsbep.state.tx.us/licensed.html. Accessed: August 18, 2006.
[48] Center for Health Statistics, *Mental Health Professionals*, supra note 39, p. 5.
[49] *Ibid*., p. 6.
[50] Texas State Board of Social Worker Examiners, *New License Requirements*. Available: http://www.dshs.state.tx.us/socialwork/sw_apply.shtm. Accessed: July 19, 2006.
[51] Center for Health Statistics, *Mental Health Professionals*, supra note 39, p. 6.
[52] *Ibid*., p. 7.
[53] *Ibid*.

Licensed Chemical Dependency Counselors

Licensed chemical dependency counselors provide counseling services to those with chemical dependency issues. In 2005, 70 Texas counties did not have a practicing licensed chemical dependency counselor, and there were 4,186 licensed chemical dependency counselors actively practicing in Texas.[54]

Marriage and Family Therapists

Marriage and family therapists provide professional therapy services to families and individuals using the application of family system theories and techniques. There were 2,790 marriage and family therapists practicing in Texas in 2005.[55]

Other Health Professions

Physician Assistants

In 2005, there were 3,375 Physician Assistants licensed to practice in Texas, with the vast majority choosing to practice in metropolitan counties. As with many health professions, the ratio of physician assistants per population has been consistently lower in Texas than in the United States as a whole. In 2005, there were 58 Texas counties without a practicing physician assistant, and the highest supply ratios were in West Texas and in the Panhandle.[56]

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[54] *Ibid*., p. 9.
[55] *Ibid*., p. 10.
[56] Statewide Health Coordinating Council, supra note 14.

Dental Hygienists

Dental hygienists perform services under the supervision of their supervising dentist. There were 8,548 dental hygienists practicing in Texas in 2005. Supply ratios for dental hygienists have been increasing in Texas since 1981, but they are still lower than the national average.[57]

Chiropractors

The supply ratio of chiropractors in the United States is consistently higher than that in Texas. In 2005, there were 4,091 chiropractors in Texas and 79 counties without a practicing chiropractor. The general trend of chiropractors appears to be away from non-metropolitan and into metropolitan counties.[58]

Podiatrists

In 2005, there were 814 podiatrists in Texas. Texas podiatry supply ratios are lower than the national average, likely due in part to the absence of a podiatry school in Texas. The highest supply ratios of podiatrists are in the Central Texas area. In 2005, 167 counties did not have a podiatrist.[59]

EMS Workers

Emergency medical services (EMS) workers are key to the health and safety of all Texans, as we all rely on EMS workers to transfer sick and injured patients to hospital

[57] *Ibid.*
[58] *Ibid.*
[59] *Ibid.*

facilities and to treat them during the time needed to reach the hospital. Salaries for EMS providers are generally low, particularly in rural areas, while the cost of meeting educational requirements for certification can be high.[60]

Recruitment and retention of EMS workers can be especially difficult for rural providers, who rely largely on volunteers. Approximately one-third of EMS personnel are volunteers and work at least one full time job. Rural providers also face difficulties associated with large transportation distances, lack of personnel with advanced training and inadequate funding to purchase needed equipment. 157 of the 254 counties in Texas have response times of greater than 10 minutes, with some counties having times as high as 136 minutes for response time and 132 for transportation time. In non-metropolitan areas in Texas, there is an average of one EMS responding agency per 6,333 people or per 422 square miles.[61]

EMS providers in urban areas also face difficult circumstances with high call volumes, rapid job burnout and traffic-related transportation problems. Funding is also a concern for urban EMS services, as funding has not increased commensurate to the increase in call volumes.[62]

Medical Radiologic Technologists

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[60] Governor's EMS & Trauma Advisory Council, Rural Task Force, *Texas Elected Officials Guide to Emergency Medical Services.* Available: http://ww.tdh.state.tx.us/hcqs/ems/TXEOG0405.pdf. Accessed: August 15, 2006.

[61] *Ibid.*

[62] *Ibid.*

Medical radiologic technologists administer radiation to patients under the direction of a medical practitioner. Medical radiologic technologists work in diagnostic radiography, nuclear medicine and radiation therapy. In 2005, there were 20,972 medical radiologic technologists in Texas. Since 2002, the Texas ratio of medical radiologic technologists per population has been higher than the national averages.[63]

Occupational Therapists

In 2005, there were 5,354 practicing occupational therapists (OTs) in Texas. The ratio of OTs per 100,000 in Texas has been rising steadily for the past decade and has exceeded the national average since the mid-1990s.[64]

Optometrists

The Texas ratio of optometrists per 100,000 population has been lower than the United States average for over two decades. There were 2,577 optometrists in Texas in 2005, and metropolitan county rates were higher than non-metropolitan county ratios.[65]

Physical Therapists

There were 8,511 physical therapists practicing in Texas in 2005. The Texas supply ratios have been increasing over the past 30 years but are still below national averages.[66]

Respiratory Care Practitioners

[63] Statewide Health Coordinating Council, supra note 14.
[64] *Ibid.*
[65] *Ibid.*
[66] *Ibid.*

In 2005, Texas had 11,768 respiratory care practitioners. Some areas have sufficient access to respiratory care practitioners, but there are signs of a shortage in some non-metropolitan areas. Data is not available on the national average of respiratory care practitioners.[67]

Other Allied Health Professions

There are between 200 and 300 professions that comprise the allied health professions. Many of these professions are reportedly experiencing shortages, but good information is hard to obtain since the State does not collect information on these professions as it does for those it licenses.[68]

Graduation data shows an increase in graduates with certificate credit programs and associate degrees in an allied health profession between 2003 and 2004, but there was a decline in 2005, which may be attributable to the implementation of the Hepatitis B immunization rule. The Hepatitis B vaccine series takes four to six months and costs approximately $180. The shots, along with required background checks, cost between $300 and $500, which can be a burden for students. Data shows that students in some allied health professions do not have exposure to blood or bodily fluid and therefore are not at high risk for contracting Hepatitis B at work.[69]

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[67] *Ibid.*

[68] Camille Pridgen, *Allied Health Workforce for Texas*, Texas Higher Education Coordinating Board (September 28, 2006).

[69] *Ibid.*

Caucasian and Hispanic students receive more associate degrees, while Black students receive more certificates. Ethnic differences in graduation rates not only lead to a less diverse workforce but also to less diversity among faculty, which can further compound the issue of recruiting minority students. Additional problems within the allied health field are insufficient faculty and clinical education sites as well as the lack of part-time and distance learning programs.[70]

United States Bureau of Labor Statistics data shows 37 allied health professions among the professions expected to grow by at least 10 percent between 2002 and 2012.[71] While we do not have sufficient data to determine the current supply of these professions in Texas, it is clear that we must ensure an adequate supply of allied health professions particularly as the Texas population grows.

Public Health Workforce

Another health workforce issue that is rarely discussed and not well documented is that of the public health sector. We rely on public health agencies to respond to terrorist events, infectious diseases and other public health threats and emergencies, but there are some signs of a public health workforce shortage. A survey conducted in October 2002 found that 30 percent of the state workforce could be lost by 2006, with health agencies being the hardest hit. A follow-up study in 2003 found a rapidly aging public health workforce with vacancy rates as high as 20 percent and turnover as high as 14 percent. The most

[70] *Ibid.*
[71] *Ibid.*

drastic shortages are in epidemiologists and public health nurses.[72] State-level data is not currently available for Texas, but given our shortages in other healthcare professions and signs of a national public health workforce shortage, it is likely that this is or will soon be an area of concern for our state.

FQHC-Related Workforce Issues

Federally qualified health centers (FQHCs) are clinics that are located in medically underserved areas or serve medically underserved populations.[73] A survey of FQHC CEOs found that the clinics have large vacancies in family physician positions as well as difficulty finding obstetrician-gynecologists and psychiatrists.[74]

Rural FQHCs make better use of available government physician workforce programs, including the National Health Service Corps,[75] federal and state medical school loan repayment programs[76] and the J-1 visa waiver program for international medical school graduates.[77]

One program that helps FQHCs recruit staff is the J-1 visa waiver program. J-1 visas are temporary visas that allow foreign medical graduates to come to the United States to

[72] Association of State and Territorial Health Officials, *State Public Health Employee Worker Shortage Report*, 2004. Available: http://www.astho.org/pubs/Workforce-Survey-Report-2.pdf. Accessed: August 1, 2006.
[73] Please see the Charge 4 Chapter for more information about FQHCs.
[74] Christopher B. Forrest, "Strengthening Primary Care to Bolster the Health Care Safety Net," *Journal of the American Medical Association*, Vol. 295, No. 9 (March 1, 2006).
[75] Please see the Charge 4 Chapter for more information about the National Health Service Corps.
[76] Please see the Charge 4 Chapter for information about National Health Service Corps loan repayment programs. Please see below for information about the Texas loan repayment programs.
[77] Christopher Forrest, supra note 74.

complete their graduate medical education. J-1 visa holders are typically required to return to their home country for two years following the completion of their training, but states may request up to 30 waivers to allow J-1 visa holders to stay. Those in the country under a J-1 visa waiver must practice for at least three years in an underserved area. In Federal Fiscal Year 2005, Texas requested the maximum 30 number of waivers and estimated that 50 more would be needed to keep interested physicians.[78]

Current Workforce Initiatives

Telemedicine

Use of telemedicine is one way to ensure access to needed specialists in areas otherwise impacted by a healthcare professional shortage. Using videoconferencing, an urban provider can talk to a rural patient and her local provider to discuss diagnoses, treatment options and patient concerns, thereby eliminating the need for burdensome travel on patients who live in more remote areas. Texas has been in the forefront of the use of telemedicine, as Texas Tech University Health Science Center in Lubbock is the site of one of the longest continuously operational telemedicine programs in the U.S.[79]

Senate Bill 1340 (79R) directed the Health and Human Services Commission (HHSC) to perform a study on the use of telemedicine within the Texas Medicaid program.[80] HHSC's report noted that Texas Medicaid reimburses hub site or local providers for

[78] United States House of Representatives, Committee on the Judiciary, Subcommittee on Immigration, Border Security, and Claims. Testimony of Leslie G. Aronovitz, Director, Health Care, United States Government Accountability Office (Washington, DC, May 18, 2006).
[79] Carrie Vaughan, *Is Telemedicine in Your Strategic Plan?*, Health Leaders (July 2006). Available: http://www.healthleadersmedia.com/print.cfm?content_id-81764. Accessed: July 19, 2006.
[80] See Texas Senate. Senate Bill 1340, 79th Legislature, 2005.

consultation or interpretation services, but it will not reimburse them for direct patient services as part of a telemedicine visit.[81] Remote site providers are reimbursed for a standard office visit so long as the services provided are within the provider's scope of practice.[82] One limitation of the Texas Medicaid reimbursement strategies for telemedicine is that the program will not reimburse providers for the investment in telecommunications equipment and infrastructure required to become an operable telemedicine site.[83] The necessary equipment costs approximately $30,000.[84]

With respect to digital imaging, Texas Medicaid reimburses for radiological interpretation performed as part of a telemedicine experience but not for other services, due to concerns about the sufficiency of other digital medical imaging to provide the full range of information needed for proper diagnoses.[85] HHSC determined as part of the Senate Bill 1340 report that the expansion of digital medical imaging in the absence of live, interactive video would not be clinically appropriate.[86]

One possible expansion of telemedicine reimbursement within the Texas Medicaid program identified by HHSC would be reimbursing for physician-delegated telemedicine services. HHSC stated that this would be feasible as long as the following conditions were met: the physician had seen the patient in person at least once; the provider at the remote site is acting under the supervision and delegation of the treating provider at the

[81] Texas Health and Human Services Commission, *Telemedicine in Texas Medicaid* (January 2006), p. 1.
[82] *Ibid.*, p. 1, 3.
[83] *Ibid.*, p. 3.
[84] Carrie Vaughan, supra note 79.
[85] HHSC, supra note 81, p. 4.
[86] *Ibid.*, p. 5.

hub site; the nature of the service is to follow up on a stable patient where the treating provider previously established a diagnosis and treatment plan; and the proper fiscal analysis and rules and regulations were put into place.[87]

Regional Health Professionals Recruitment

The Regional Health Professionals Recruitment program is run by the Area Health Education Centers (AHECs), initially through grant funding from the Robert Wood Johnson Foundation. A regular recruitment process works to recruit providers and assists providers in matching with appropriate communities. Recruiters also assist with community development, economic impact awareness, community toolkits and individualized placement needs assessment.[88] They work with HealthFind, an annual rural health care provider recruiting event, and developed TexasHealthMatch.com to assist rural and medical underserved communities in recruiting and retaining providers.[89]

Loan Repayment Programs

The Texas Higher Education Coordinating Council administers two key health-related loan repayment programs - the Physician Education Loan Repayment Program (PELRP) and the Dental Education Loan Repayment Program (DELRP).

PELRP was authorized by the Legislature in 1985 to address the need for more primary care physicians. Physicians may receive a maximum of $9,000 per year in loan

[87] *Ibid.*, p. 6.
[88] East Texas Area Health Education Center, *Major Projects 2006*.
[89] Office of Rural Community Affairs, *HealthFind.* Available: http://www.orca.state.tx.us/index.php/Rural+Health/Healthcare+Recruitment/HealthFind. Accessed: August 24, 2006.

repayment for a maximum of five years in exchange for providing primary care services in a state-recommended HPSA or by working for the Department of State Health Services, Texas Department of Criminal Justice, or Texas Youth Commission. Additional loan repayment assistance is available for physicians in PELRP who meet stricter federal standards. No money is distributed to PELRP physicians until at least one year of service has been provided. In May 2006, 75 physicians were participating in the program with an additional eight enrollees anticipated during FY 2007.[90]

DELRP was authorized by the Legislature in 1999 to address dental shortages. General and pediatric dentists may receive $10,000 per year in loan repayment in exchange for practicing in Dental HPSAs. Dentists who also meet federal requirements - two years of service and practice in a public or non-profit facility - may receive up to $20,000 per year toward their educational loans. As of May 2006, 10 dentists were participating in DELRP.[91]

AHEC Professional Corp

The AHEC Professional Corp is a joint Texas-Missouri AHEC program to assist underserved areas in finding and retaining health care providers. The Corp Program provides education and training on cultural competency, health resources for communities and information on bioterrorism and other current topics. Enrolled providers are offered up to $9,000 in education awards and loan repayments.[92]

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[90] Senate Health and Human Services Committee, Testimony of Lesa Moller, Texas Higher Education Coordinating Board (Austin, Tex., May 16, 2006).
[91] *Ibid.*
[92] East Texas Area Health Education Center, supra note 88.

Rural Recruitment and Retention Study

House Bill 916 (79R) directed the Statewide Health Coordinating Council to work with Texas AHECs to review recruitment and retention programs in rural and underserved areas.[93]

Recruitment and Retention of Health Care Providers in Underserved Communities in Texas was released in September 2006 and presented information from a survey conducted by the East Texas AHEC of facilities and providers in seven communities. Reported problems with practicing in a rural environment included lower salaries, older facilities and a disproportionate amount of Medicaid or uninsured patients. Successful recruiting measures for rural communities focused on outreach and "grow your own" programs. An interesting finding from the survey and report was the reluctance of health care providers to participate in the survey or help their area be designated as medically underserved due to a desire to protect their patient base. While this may be an understandable business motive, it will seriously hinder addressing the health care access concerns in affected areas.[94]

[93] Texas Health Care Policy Council, Workforce Partnership Subcommittee, Testimony of the Health Professions Resource Center and East Texas AHEC (April 20, 2006).
[94] Texas Department of State Health Services, Health Professions Resource Center, and East Texas AHEC, *Recruitment and Retention of Health Care Providers in Underserved Communities in Texas*, E Publication #25-12501 (September 2006). Available: http://www.dshs.state.tx.us/CHS/hprc/hb916rep.pdf. Accessed: October 24, 2006.

The report recommends increasing outreach to high school students in rural areas, providing additional loan repayment programs, promoting the positive aspects of rural living and providing funds for upgrading rural facilities.[95]

Diversity in Health Workforce Education

Texas AHECs are sponsoring regional conferences between February and July 2007 to involve interested parties in discussing evidence-based best practices to promote diversity in the healthcare workforce.[96] Data from the individual health professions shows a lower number of non-Caucasians in many health professions as compared to the overall Texas population.

Statewide Health Coordinating Council

The Statewide Health Coordinating Council develops strategic health plans for Texas called the *Texas State Health Plan*. The plan is due to the Governor by November 1st of each even numbered year. Since 1997, one focus of the Statewide Health Coordinating Council and the *Texas State Health Plan* has been ensuring an adequate healthcare workforce.[97] The Statewide Health Coordinating Council provides information to the Governor and the Legislature on the status of the healthcare workforce in Texas along with recommendations on ensuring the existence of an adequate supply of healthcare professionals.

Texas Health Care Policy Council

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[95] *Ibid.*
[96] East Texas Area Health Education Center, supra note 88.
[97] Statewide Health Coordinating Council, supra note 14.

Created by House Bill 916 (79R), the Texas Health Care Policy Council was directed to maintain the Workforce Planning Partnership Subcommittee to monitor the health workforce condition and needs of Texas.[98]

The Health Care Policy Council released its draft report entitled, *Commitment to Health Workforce Planning: A Strategy for Addressing Texas' Health Workforce Needs*. The Report complements to 2006-2007 *State Health Plan Update* by reviewing the available workforce data and including recommendations for action. The recommendations focus on the need for more and better workforce data, better coordination and collaboration among educational institutions and more efficient use of workforce resources.[99]

The Health Education Training Centers Alliance of Texas

The Health Education Training Centers Alliance of Texas was formed to improve the healthcare workforce. The Alliance is a partnership between health science centers, state agencies and health-related associations. It promotes community health projects and attempts to improve the supply, distribution, diversity and retention of healthcare professionals through training and education.[100]

Austin Healthcare Collaborative Jobs to Careers Project

The Austin Healthcare Collaborative Jobs to Careers program is a collaborative program involving Austin Community College, the Greater Austin Area Workforce Board, the

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[98] Texas House of Representatives, House Bill 916, 79th Legislature, 2005.
[99] Texas Health Care Policy Council, *Commitment to Health Workforce Needs: A Strategy for Addressing Texas' Health Workforce Needs: Strategic Plan 2006-2011* (draft) (October 2006).
[100] *Texas Cooperative Agreement Program.* Available: http://bhpr.hpsa.gov/interdisciplinary/03abstracts.hetc.htm. Accessed: March 9, 2006.

Seton Family of Hospitals, St. David's HealthCare, the Central Texas Workforce Intermediary Initiative and the Health Industry Steering Committee of the University of Texas's Lyndon B. Johnson School of Public Affairs. The project, which is one of nine projects nationwide chosen for a Robert Wood Johnson Foundation grant for Jobs to Careers programs, focuses on reducing healthcare employee turnover and increasing the frontline health workers in the Central Texas region.[101]

Nurse-Specific Measures

Several workforce improvement strategies have been implemented to address the nursing shortage.

The Texas Nurses Association runs a program that designates certain hospitals as Nurse Friendly Hospitals. This designation can help hospitals recruit and retain nurses. The AHECs have been working with hospitals to achieve the designation, which requires the hospital to meet 12 criteria.[102] The criteria are: control of nursing practice, including a delineated nursing governance model and a staffing plan that reflects input from direct care nurses; safety of the work environment; putting systems in place to address patient care concerns; a nursing orientation plan exists; there is a chief nursing officer; professional development is offered for nurses; competitive wages are awarded; nurse recognition occurs; balanced lifestyles are encouraged; there is a zero tolerance policy for

[101] *Work*Source. "Local Partnership Receives $428,240 Grant from the Robert Wood Johnson Foundation to Support Frontline Healthcare Workers," (October 19, 2006). Available: http://www.utexas.edu/research/cshr/new/rwjf_grant_release.pdf. Accessed: November 1, 2006.
[102] East Texas Area Health Education Center, supra note 88.

abuse of nurses; middle management is accountable for its actions; and quality initiatives are in place.[103]

Texas has the Texas Center for Nursing Workforce Studies to ensure that accurate and timely information is available on the state of the nursing workforce in Texas. The Center was created by House Bill 3126 (78R) to collect and analyze data on nursing education and nursing workforce issues. The Center exists as part of the Center for Health Statistics and works with the Nursing Workforce Advisory Committee that was created for that purpose as part of the Statewide Health Coordinating Council. Since the Center was first formed in 2003, it has released reports on nurses in hospitals, nursing education trends, increasing RN graduates in Texas and nursing demographics and migration in Texas.[104]

Senate Bill 132 (79R) was authored by Senator Nelson to address the nursing shortage. Senate Bill 132 created tuition exemptions for children of nursing faculty who attend the school at which their parent works. It also established a $500 tuition exemption for nurse preceptors and their children. The professional nursing program faculty member home loan program was created by Senate Bill 132 to assist nursing faculty in obtaining low interest home loans; $5 million was allocated to this program.[105]

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[103] Texas Nurses Association, *Nurse-Friendly Hospital Criteria*. Available: http://www.texasnurses.org/wkplaceadv/NF/nurse-friendly.htm. Accessed: May 19, 2006.
[104] Texas Health Care Policy Council, Workforce Planning Partnership Subcommittee, Testimony of Aileen Kishi (Austin, Tex., August 24, 2006).
[105] Texas Senate. Senate Bill 132, 79th Legislature, 2005.

Additionally, the bill added certain retirees employed as faculty members in certain professional nursing programs between the beginning of the 2005 fall semester and the end of the 2015 spring semester to the list of persons who cannot have benefit payments withheld under the Teacher Retirement System. Senate Bill 132 allows the use of professional nursing shortage reduction program grants on costs related to identifying, developing or implementing innovative methods to make the most effective use of limited professional nursing program faculty and other resources. The bill also allows the use of nursing faculty enhancement grants under the professional nursing shortage reduction program to assist nursing programs in the education, recruitment and retention of faculty.[106]

The Texas Higher Education Coordinating Board and the Center are implementing the portion of Senate Bill 132 that required a yearly target of graduates from nursing programs to be developed and issuing recommendations on how to meet that goal. The Center used Health Resources and Service Administration Supply and Demand Models to conduct the necessary analysis.[107] The report, released in November 2006, states that a four-fold increase in graduates of initial entry nursing programs must be achieved by 2020 to meet demand, which is expected to rise by 86 percent between now and 2020. The report recommends tying additional funding with accountability measures for the nursing educational programs involved. Other measures to maintain the nursing

[106] *Ibid.*
[107] Texas Center for Nursing Workforce Studies, *Progress Report on SB 132* (June 19, 2006).

workforce must also be considered, including encouraging nurses to delay retirement, improving the workplace and ensuring competitive wages are offered. [108]

The Coordinating Board's report on student completion rates in initial RN programs shows a 56 percent completion rate within two years of starting an initial RN program and that financial concerns drive many of these students to take on part- or full-time work, which could hinder their educational progress. Work-study programs and financial aid were discussed as means of combating the financial issues that hinder some nursing students. Faculty needs were also cited as a problem, with the Coordinating Board finding that nursing programs need to increase full-time faculty by 54 percent to meet the nursing needs by 2010.[109]

Long Term Services and Supports Initiative

The Texas Department of Aging and Disability Services (DADS) is currently working on developing a plan to address the turnover in the long term services and supports industry. DADS was selected to receive technical assistance in this initiative through the Centers for Medicare and Medicaid Services. Current turnover of direct service workers in the long term services industry ranges from 40 to 400 percent per year, which creates inconsistencies in service provision to clients and costs relating to recruiting and training

[108] Texas Center for Nursing Workforce Studies, Texas Department of State Health Services Center for Health Statistics, and the Statewide Health Coordinating Council's Texas Center for Nursing Workforce Studies Advisory Committee, *The Supply of and Demand for Registered Nurses and Nurse Graduates in Texas*, Publication No. 25-12514 (November 1, 2006).
[109] Texas Higher Education Coordinating Board, *Strategies for Increasing Student Completion Rates in Initial RN Licensure Programs* (October 2006).

new workers for facilities. The DADS study is taking place from July 2006 through August 2007.[110]

Recommendations

1. **Implement a minimum data set for health licensing boards.**

   Rationale: Ensuring that all health licensing boards obtain the same information from their licensees will provide uniform data to ensure better workforce analysis. Only with sufficient information can we truly comprehend and address any workforce issues in Texas.

2. **Address formula funding issues.**

   Rationale: Current formula funding does not provide start up costs for expanding health professional school programs or for hiring the additional staff needed to accommodate larger class sizes. The formula funding system must be changed to acknowledge that faculty shortages prohibit many health professional educational programs from admitting additional qualified students. This will also require earmarking of funds to ensure that money allocated for particular programs is actually dedicated to that program.

3. **Increase the number of GME slots in Texas.**

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[110] Department of Aging and Disability Services, Center for Policy and Innovation, Policy Analysis and Support, *Direct Service Worker Intensive Technical Assistance Profile* (September 19, 2006).

Rationale: This is a cost-effective way of increasing the physician workforce in Texas as physicians tend to practice within 100 miles of where they complete their residencies.

4. **Address faculty shortages in health care professional schools.**

Rationale: Health professional schools can not increase their class sizes without the necessary faculty. This will require increases in faculty salaries and/or other sufficient incentives for professionals to devote themselves to teaching.

5. **Incentivize providers to serve in underserved areas.**

Rationale: Incentives are needed to address the mal-distribution of health professionals and ensure that Texas citizens have access to quality health care no matter where they choose to live within the state.

6. **Expand loan repayment programs.**

Rationale: Pursuing the necessary education to become a health professional can be an expensive task and leave students with large amounts of debt, which can limit students' choices of work environment and location. Expanding loan repayment programs will allow more students from disadvantaged backgrounds to pursue health education without the concerns of overwhelming debt and create incentives for professionals to work in underserved areas.

7. **Create a scholarship program to support students enrolling in the rural medicine programs.**

Rationale: The Rural Osteopathic Medical Education program is specifically designed for medical students seeking to practice in rural areas. Scholarship support for this and other similar programs could enable students who are interested in rural practice but concerned about the financial impact of such work to pursue their goals without fear of overwhelming debt, thereby increasing the number of rural physicians.

8. **Consider reimbursing for physician-delegated telemedicine.**

Rationale: This would allow Medicaid reimbursement for telemedicine services where the provider with the patient is a non-physician who is practicing under the supervision of the consulting telemedicine physician. Authorizing such reimbursement would make multidisciplinary teamwork across geographic regions more feasible and help increase the use of telemedicine in underserved areas. The inability to reimburse for such office visits is one of the findings of the HHSC's Senate Bill 1340 report.

9. **Allow health professional students to take basic science classes with students from other health professional programs.**

Rationale: Currently, each health professional program sponsors its own classes on issues such as anatomy, pharmacology and pathology, which could be better taught in joint classes. The Texas Higher Education Coordinating Board should work with the health licensing boards to determine the feasibility of institutions combining their introductory classroom instruction to allow nursing, medical and other health professional students to attend the same classes. This may help alleviate some of the faculty shortage issues in various health professions.

10. Recognize hospitals with exemplary nurse staffing.

Rationale: Hospitals with strong nurse staffing should be recognized by the state for their work in creating safe environments for workers and patients alike. Information about hospitals' staffing should also be available to the public as they choose hospitals for elective or pre-scheduled procedures.

11. Revise the rules on Hepatitis B vaccines.

Rationale: Requiring the Hepatitis B series of vaccines for health professions with potential exposure to blood or bodily fluids makes good public health sense. We do not want, however, this rule to limit the ability of students to complete their training or to hamper those who do not have such potential exposure, such as psychologists and licensed

professional counselors. Hepatitis B vaccines should be required only for health professions with such potential exposure and only one shot should be required upon admission, with the rest being required on schedule during training or while working pursuant to safety protocols from the Centers for Disease Control and Prevention.

12. **Include higher education representation on the Interagency Coordinating Council for HIV and Hepatitis.**

    Rationale: Policies on HIV and Hepatitis prevention impact health professional students as well as health professionals. To ensure that this impact is considered by the Council, the Texas Higher Education Coordinating Board should be added to the Council.

13. **Research the feasibility of providing low or no cost immunizations to disadvantaged students.**

    Rationale: The cost of the required vaccines can be an impediment to pursuing a health career for some low income students. The Department of State Health Services and Higher Education Coordinating Board should study the best way to ensure that vaccine costs do not prohibit students from entering a health profession.

14. **Provide additional funding for baccalaureate nursing programs.**

Rationale: Schools should be incentivized to expand these programs and ensure an adequate, highly qualified nursing workforce.

15. **Allow nursing schools to use clinical or adjunct faculty to teach clinical courses.**

Rationale: Nursing schools are currently using school faculty to teach clinical courses in hospitals. These programs should use clinical or adjunct faculty to allow their full time classroom faculty to focus on their class work and take advantage of high-skilled nurses in hospitals who would like to teach but not be full-time instructors.

16. **Require H1B visa recipients to work in an area that meets the Texas Conrad 30 requirements upon completion of their training.**

Rationale: Unless H1B visa recipients continue to work for their university sponsor, they should be required to work in underserved areas after their training is complete, just as the Conrad 30 or J-1 visa waiver program requires. This will ensure better access to care in underserved areas.

17. **Direct the Higher Education Coordinating Board and Board of Nurse Examiners to reform the nursing curriculum in Texas.**

Rationale: We need nurses with strong educational backgrounds in science, evidence based nursing and quality and safety best practices. The boards should work together to ensure

Texas nursing schools are offering the best program available. Given the many advances in health care and in nursing practice, a full review of the curriculum is needed.

18. Ensure adequate workforce data regarding the allied health professions.

Rationale: We lack accurate, timely information about the status of the allied health workforce. In order to address any shortages, we must know they exist. In order to do this, the State needs to create a statutory definition of "allied health professional" and require reporting of necessary workforce data on these professionals from the relevant licensing boards and educational programs.

19. Expand the tuition and home loan incentive programs for nursing faculty to allied health faculty.

Rationale: Senate Bill 132 (79R) established tuition reductions and home loan incentive programs for nursing faculty. Allied health programs report similar faculty shortages and problems recruiting faculty. Expanding the Senate Bill 132 programs will give allied health professional programs additional tools with which to recruit and retain faculty.

20. Provide incentives for universities and health science centers to provide community-based, on-line, or distance learning programs.

Rationale: Allowing more distance or non-traditional learning formats expands health professional education to those in rural areas, at-home parents, those seeking a second career and others who can not attend daytime classes at a local university or health science center. Expanding the pool of potential health professional students will increase the workforce supply and diversity within the health care professions.

21. **Recognize nursing programs that achieve an 85 percent completion rate for initial registered nurse graduates.**

Rationale: The current statewide completion rate for initial registered nurse graduates is 56 percent. To meet the nursing workforce needs of the state, we need to improve this rate. The Texas Higher Education Coordinating Board, based on its study of initial registered nurse programs, recommended a goal of 85 percent completion rate. Schools that make the necessary improvements to meet this goal should be recognized.

Charges 3 and 4: FQHCs

FQHC-Related Portion of Charge 3: Evaluate the state's use of the National Health Services Corps and Federally Qualified Health Centers (FQHCs) to address the needs of the Medicaid/Medicare and underinsured populations.

Charge 4: Examine the strategies used by other states that have had success with FQHCs and make recommendations for increasing the number of FQHCs in Texas.

Federally Qualified Health Centers

Background

The federally qualified health center (FQHC) program was established in the 1960s[1] with the goal of improving the health status of underserved populations.[2] FQHCs must be located in medically underserved areas or serve medically underserved populations[3] and have a community-majority board. The boards, ranging in size from nine to 25 members, must be made of a majority of patients of the clinic and must reflect the demographics or the patients and community served by the FQHC.[4]

FQHCs must also meet a variety of governance requirements. The management team generally consists of an executive director, medical director, chief financial officer and

[1] Texas Senate Health and Human Services Committee, Testimony by Jose Camacho, Executive Director, Texas Association of Community Health Centers, (Austin, Tex., May 16, 2006).
[2] Division of Family and Community Health Services, Texas Primary Care Office, Texas Department of State Health Services, *Fast Facts about FQHCs*, February 27, 2005.
[3] Department of Health and Human Services, *Bolstering Community Health Centers*. Available: http://www.hhs.gov/news/factsheet/center.html. Accessed: March 21, 2006.
[4] Texas Association of Community Health Centers, *2005 Membership Directory*, p. 22.

chief operating officer.[5] The team must meet performance and accountability requirements with respect to the administrative, clinical and financial operations of the FQHC.[6] Fees must be charged on a sliding scale, with full discounts and a nominal copay for those at or below 100 percent of the Federal Poverty Level (FPL), sliding discounts and copays for those between 101 and 199 percent of FPL and full charges for those at or above 200 percent of FPL.[7]

FQHCs must provide the following services either directly or through contract: primary medical, dental and mental health care, substance abuse services, diagnostic lab and x-ray, prenatal and perinatal care, interpretation, cancer and other disease screening, eye and ear screening for children, family planning services, emergency medical care, pharmacy, case management, child and adult immunizations, well child services, outreach and education, transportation and eligibility or enrollment services.[8]

In exchange for providing these services to the underserved, FQHCs receive financial benefits. They have access to federal and state grants, receive enhanced revenue through increased Medicaid and Medicare reimbursements, have access to medical malpractice coverage under the Federal Tort Claims Act, receive Public Health Service Drug Pricing Discounts for pharmaceutical products, have access to federal loan guarantees for capital improvements, have access to on-site Department of Health and Human Services out-stationed eligibility workers to provide Medicaid and CHIP enrollment services, receive

[5] *Ibid.*
[6] *Bolstering Community Health Centers*, supra note 3.
[7] *TACHC 2005 Membership Directory*, supra note 4, p. 23.
[8] *Fast Facts about FQHCs*, supra note 2.

reimbursement from Medicare for "first dollar" services because deductibles are waived when FQHCs are providing care, have access to the Vaccines for Children Program and have access to National Health Service Corps placements to provide medical, dental and mental health provider staff.[9]

FQHCs obtain revenue from a variety of sources. Averages are: 29 percent from federal grants, 27 percent Medicaid, 15 percent state and local grants and contracts, 12 percent patient self-pay, 6 percent Medicare, 2 percent CHIP or other public program and 7 percent from other revenue sources.[10]

Clinics may also receive FQHC Look-Alike status. FQHC Look-Alikes must meet all the requirements of a full FQHC except that they do not receive grant funding from the Bureau of Primary Health Care, which means it is not subject to the same competitive process as that for receiving full FQHC status.[11] Look-Alikes receive many of the benefits of full FQHCs.[12]

The FQHC program has proven to be successful. Areas with nearby FQHCs have decreased levels of unmet health needs and lower rates of emergency department use and

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[9] Texas Association of Community Health Centers, *What are the Benefits of FQHC Status for a Community and an Organization Considering Such a Development?*. Available: http://www.tachc.org/Community_Resources/Community_Development/Benefits.asp. Accessed: July 6, 2006.
[10] Texas Senate Committee on Health and Human Services, Testimony by Jose Camacho, supra note 1.
[11] *Fast Facts about FQHCs*, supra note 2.
[12] Texas Association of Community Health Centers, *What is an FQHC Look-Alike Clinic and what are the benefits?*. Available: http://www.tachc.org/Community_Resources/Community_Development/Look_Alike.asp. Assessed: February 24, 2006.

hospitalizations for the uninsured.[13] FQHCs also have a positive impact on an area's rates of infant mortality, childhood immunizations, hospital lengths of stay, control of chronic conditions and overall Medicaid costs.[14] For example, in 2003, the average cost of serving a patient in an FQHC was $479 annually, which was 10 times less than the average annual per capita spending on personal health care.[15] The White House Office of Management and Budget called the health center program one of the 10 most successful federal programs and the most successful Department of Health and Human Services program in 2005.[16] FQHCs treat largely minority patients, with 69 percent identifying themselves as Hispanic, 11 percent as Black, 16 percent as Anglo and 4 percent as other.[17]

A September 2003 study conducted by George Washington University found that FQHCs helped reduce racial and ethnic disparities in health status through the following factors: location in medically underserved areas, provision of comprehensive primary care and social services, openness to all residents regardless of ability to pay, governance by a community board and adherence to performance standards.[18]

FQHCs in Texas

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[13] Christopher B. Forrest, MD. PhD, "Strengthening Primary Care to Bolster the Health Care Safety Net," *Journal of the American Medical Association*, Vol. 295, No. 9 (Chicago, Ill., March 1, 2006).
[14] National Conference of State Legislatures, "Community Health Centers: Serving the Nation's Most Vulnerable Populations," *State Health Notes*, Vol. 24, No. 414 (Denver, Co., February 23, 2004).
[15] National Conference of State Legislatures, "Community Health Centers: An Update," *Legisbrief*, Vol. 13, No. 1 (Denver, Co., January 2005).
[16] *Ibid.*
[17] Texas Senate Health and Human Services Committee, Testimony by Jose Camacho, supra note 1.
[18] NCSL, *Serving the Nation's Most Vulnerable*, supra note 14.

FQHCs play an important role in Texas, where they cared for 562,065 patients in 2004.[19] Texas had 40 FQHCs in 2004,[20] behind only California with 87 and New York with 50. By 2005, Texas had 50 FQHCs operating at 334 delivery sites.[21] Texas FQHCs had 34 out-stationed eligibility workers to provide on-site Medicaid enrollment in 2004 and had a statewide economic impact of $376.2 million.[22]

Texas has the highest number of Primary Care and Dental Health Professional Shortage Areas (HPSAs) among the five most populated states and ranks second only to California in the number of Mental Health HPSAs, demonstrating the need for FQHCs in many parts of Texas. In Fiscal Year 2006, Texas committed $5 million in General Revenue to FQHCs, while California and New York have $56.3 million and $16.6 million in state funds, respectively.[23]

Federal Legislation

In August 2001, President Bush announced a five year plan to increase the number of FQHCs nationwide; it is known as the New Access Point Initiative.[24] The goal was to increase the number of health center sites from 3,200 in 2001 to 4,400 in 2006 and to increase the annual number of patients served at FQHCs from 10.3 million to 16 million

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[19] *TACHC 2005 Membership Directory*, supra note 4, p. 8.
[20] Kaiser State Health Facts, *50 State Comparisons: Number of Federally-Funded Federally Qualified Health Centers, 2004*. Available: http://statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Providers+%26+Service+Use&subcategory=Federally+Qualified+Health+Centers&topic=Total+FQHCs&gsaview=1. Accessed: February 9, 2006.
[21] Texas Senate Health and Human Services Committee, Testimony by Connie Berry, Manager, Primary Care Office, Texas Department of State Health Services, (Austin, Tex., May 16, 2006).
[22] *TACHC 2005 Membership Directory*, supra note 4, p. 11.
[23] Texas Senate Health and Human Services Committee, Testimony by Connie Berry, supra note 21.
[24] *TACHC 2005 Membership Directory*, supra note 4, p. 9.

in the same time frame.[25] Since 2006 patient numbers are not yet available, it is unclear if this goal was met. In the first four years of the program, Texas FQHCs received $24 million in federal money.[26]

Congress is considering legislation to further fund FQHCs. House Resolution 5573, the Health Centers Renewal Act of 2006, passed the House on June 21, 2006 and was referred to the Senate Committee on Health, Education, Labor and Pensions on June 22, 2006. No further action was taken on this bill since June.[27] The bill includes appropriations for the FQHC program for Fiscal Years 2007-2011. The version of HR 5573 sent to the Senate Committee appropriates the following amounts to the program: $1,963,000,000 for fiscal year 2007, $1,999,000,000 for fiscal year 2008, $2,015,000,000 for fiscal year 2009, $2,041,000,000 for fiscal year 2010, and $2,041,000,000 for fiscal year 2011.[28]

State Legislation

The 78th Texas Legislature acknowledged the importance of FQHCs to Texas through Senate Bill 610, which created the FQHC Incubator Program. SB 610, authored by Senator Nelson, authorized the Department of State Health Services to make grants to establish new FQHCs or to expand existing facilities that could qualify as FQHCs. The grants could be used for planning, development, capital improvements or transitional

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[25] *Bolstering Community Health Centers*, supra note 3.
[26] *TACHC 2005 Membership Directory*, supra note 4, p. 10.
[27] Major Congressional Actions, HR 5573 (109th Congress, 2d Session). Available: http://thomas.loc.gov/cgi-bin/bdquery/z?d109:HR05573:@@@R. Accessed: November 13, 2006.
[28] United States House of Representatives. HR 5573, 109th Congress, 2d Session (2006).

operating support.[29] $10 million was appropriated for the Incubator Program by the 78th Legislature and again by the 79th Legislature.[30]

The Incubator Program has been implemented by the Texas Primary Care Office in the Department of State Health Services. The Primary Care Office staff works with existing FQHCs and organizations that are in the process of converting to FQHC status. The first Incubator grants were awarded in Fiscal Year 2005, and four existing FQHCs received awards that resulted in additional federal funding. In Fiscal Year 2005, two new FQHCs received federal grants that had received Incubator grants. In FY 2006, eight new FQHCs were funded.[31] The Incubator Program continues to help clinics prepare for and achieve FQHC status.

National Health Service Corps

Background

The National Health Service Corps (NHSC) was developed in 1972 to serve the underserved. The NHSC works to place providers in underserved communities and increase access to primary care.[32] The NHSC administers a number of programs to recruit providers and match them with communities in need.

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[29] Texas Senate. Senate Bill 610, 78th Legislature, 2003.
[30] *TACHC 2005 Membership Directory*, supra note 4, p. 23.
[31] Texas Senate Health and Human Services Committee, Testimony by Connie Berry, supra note 21.
[32] National Health Service Corps, *About NHSC*. Available: http://nhsc.bhpr.hrsa.gov/about. Accessed: August 2, 2006.

In Texas, 58 percent of our NHSC providers work at FQHCs. The Texas Primary Care Office partners with NHSC for recruiting and placements in Texas.[33]

Ambassador Program

NHSC ambassadors work either with a school or with a community. The campus-based Ambassador Program provides ambassadors to school campuses to educate students and promote careers in primary care. Ambassadors also help train and support interested students. Community-based ambassadors work to increase access to health care in their assigned communities. They have affiliations with organizations committed to serving the underserved and help connect clinicians and students with those organizations with the goal of recruiting those clinicians and students to the ambassador's region.[34]

Texas currently has two community-based ambassadors, both of whom are stationed in the Rio Grande Valley, and 34 campus-based ambassadors located in the health science center campuses or at nursing schools. The Ambassadors Program does not currently link its efforts with the Texas Primary Care Office even though it is the state liaison to NHSC.[35]

Scholarship Program

NHSC also has a scholarship program that covers primary care physicians, physician assistants, nurse practitioners, certified nurse midwives, dentists, and psychiatrists.

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[33] Texas Senate Health and Human Services Committee, Testimony by Connie Berry, supra note 21.
[34] National Health Service Corps. *Ambassador Overview*. Available: http://nhsc.bhpr.hrsa.gov/ambassadors/prog_overview.asp#overview. Accessed: July 10, 2006.
[35] *Ibid.*

NHSC scholarship recipients commit to practice for a period of time in a high need shortage area in exchange for the scholarship money.[36] One year of service must be performed for each year of scholarship support, and there is a two-year minimum service requirement.[37]

The scholarship program is a competitive application process, and only seven applications are accepted for each NHSC scholarship spot.[38] Benefits include full payment of up to four years of tuition and fees, reasonable educational expenses and a monthly stipend during the scholarship period. While the benefits are generous, the penalties for failing to meet service obligations are strict. Scholars must pay back triple the amount of scholarship payments they received plus interest within one year of breach of their commitment. Federal prosecution and loss of license to practice in some states are also possible penalties of defaulting on scholarship debt.[39]

Texas currently has 35 NHSC scholarship recipients. While the program has been successful in getting more practitioners into HPSAs, one study has shown that NHSC physicians leave FQHC positions sooner than their non-NHSC colleagues.[40]

Loan Repayment Program

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[36] Texas Senate Health and Human Services Committee, Testimony by Connie Berry, supra note 21.
[37] National Health Service Corps, *Ambassador Toolkit: Scholarship Program*. Available at: ftp://ftp.hrsa.gov/nhsc/ambassadors/SCHOLARSHIP_PROGRAM.pdf. Accessed: July 10, 2006.
[38] Christopher B. Forrest, supra note 13.
[39] *Ambassador Toolkit: Scholarship Program*, supra note 45.
[40] Texas Senate Health and Human Services Committee, Testimony by Connie Berry, supra note 21.

NHSC loan repayment recipients receive assistance in paying their educational loans in exchange for service at approved sites. Practitioners in this program have a service commitment of at least two years full-time clinical practice at an approved clinic; after the first two years, the program matches one year of payment with one year of service. Recipients receive up to $25,000 per year in repayments on health-related student loans during the first two years of service as well as 39 percent assistance payments on federal taxes owed for the loan repayment amounts. If the recipient's service is extended beyond the initial two year requirement, up to $35,000 per year is received.[41]

Eligible practitioners for the NHSC loan repayment program include: physicians specializing in family medicine, general pediatrics, general internal medicine, general psychiatry, or obstetrics and gynecology; primary care nurse practitioners; primary care physician assistants; certified nurse-midwives; dentists; dental hygienists; and mental or behavioral health professionals, including clinical or counseling psychologists, clinical social workers, licensed professional counselors, marriage and family therapists or psychiatric nurse specialists.[42]

Loan repayment recipients who fail to meet their service obligations must repay all of the loan repayments and tax assistance for the period not served, pay a $7500 per month penalty for time not served and pay the maximum allowable interest on the penalty amounts from the date of the breach.[43]

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[41] National Health Service Corps, *Ambassador Toolkit: Loan Repayment Program*. Available at: ftp://ftp.hrsa.gov/nhsc/ambassadotrs/LRP/pdf. Accessed: July 10, 2006.
[42] *Ibid.*
[43] *Ibid.*

Currently 129 NHSC loan repayment recipients are practicing in Texas.[44]

Ready Responders

The Ready Responder program was created by then-Secretary of the Department of Health and Human Services Tommy Thompson to respond to major medical crises in the United States. The program has a three year service requirement, and participants are eligible for the NHSC Loan Repayment Program.[45]

Eligible practitioners are physicians who have completed primary care residencies, general practice dentists, primary care certified nurse practitioners, primary care physician assistants, clinical psychologists and social workers. The benefits of being a Ready Responder include the following: compensation, special professional pay, 30 days paid annual leave, tax-free allowances for food and housing, malpractice coverage under the Federal Torts Claims Act, non-contributory pension plan, non-contributory health care benefits, Department of Defense benefits, Department of Veterans Affairs benefits and duty travel and transportation expense coverage.[46]

When they are not responding to a crisis, Ready Responders work in HPSAs.[47] Texas has three Ready Responders practicing in state HPSAs.[48]

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[44] Texas Senate Health and Human Services Committee, Testimony by Connie Berry, supra note 21.
[45] National Health Service Corps, *Ambassador Toolkit: Ready Responders Program*. Available: ftp://ftp.hrsa.gov/nhsc/ambassadors/RR.pdf. Accessed: July 10, 2006.
[46] *Ibid.*
[47] *Ibid.*
[48] Texas Senate Health and Human Services Committee, Testimony by Connie Berry, supra note 21.

Additional NHSC Recruiting and Retention Programs

NHSC can also help individual clinics and communities. NHSC helps recruit primary care physicians, primary care nurse practitioners, primary care physician assistants, certified nurse-midwives, dentists and dental hygienists and mental health professionals. NHSC staff helps communities and sites to develop clinics, build partnerships to mobilize local resources, design and implement a discounted fee schedule, maximize revenues from certain federal programs, identify ways to support uncompensated care through other grant programs, establish an integrated system of care that includes the uninsured and underinsured and link with other communities that have sites.[49]

Communities are eligible for NHSC help if they serve high need populations. Clinics are eligible for assistance if they are located in a HPSA, accept Medicaid and Medicare assignments, maintain a discounted fee schedule that ensure no financial barriers to care for those at or below 200 percent of the Federal Poverty Level, function as part of a system of care that provides a full range of services, and maintain full-time practice hours.[50] Many communities and sites in Texas would qualify for such assistance.

Recommendations

1. **Encourage the National Health Service Corps' Ambassador Program to work more closely with the Texas Primary Care Office.**

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[49] National Health Service Corps, *Information for Communities and Sites*. Available: ftp://ftp.hrsa.gov/nhsc/factsheets/Information-for-Communities-and-Sites.pdf. Accessed: July 6, 2006.
[50] *Ibid.*

Rationale: Currently the Primary Care Office is the liaison with NHSC, but the NHSC Ambassador Program is not linked with the Office. The Office has valuable information about the Texas primary care workforce and areas of great need and would be an asset to the Ambassador Program.

Charge 5: Skin Cell Research and Technology

Study and make recommendations relating to policy issues surrounding the use of emerging skin cell research and other technologies.

Background

Adult and embryonic stem cells have been touted in the medical world as potential cures for diseases such as Parkinson's and Alzheimer's. Adult stem cells do not have the pluripotency - or potential to develop into the same array of different types of cells - of embryonic stem cells, but embryonic stem cell research continues to generate moral and ethical questions about the appropriateness of such research.

In response to this dilemma, scientists have begun researching new ways to create cells with the same potential as embryonic stem cells but without the controversy. Several of these approaches use skin cells as a basis for creating pluripotent cells.

In an August 2005 study, scientists from Harvard announced that they had turned skin cells into embryonic stem cell-like cells without using human eggs or creating any new embryos. The Harvard scientists, in effect, created a hybrid cell by merging a skin cell with an embryonic stem cell.[1] The hybrid cells grew into tight, round colonies similar to embryonic stem cell growth and were able to multiply indefinitely like embryonic stem

[1] Rick Weiss, "Skin Cells Converted to Stem Cells," *Washington Post* (August 22, 2005). Available: http://www.washingtonpost.com/wp-dyn/content/article/2005/08/21/AR2005082101180.html. Accessed: February 6, 2005.

cells.[2] Before the cells could be used for medical treatment, the extra DNA contained in the hybrid cells would have to be removed. Research teams in Illinois and Australia have reported some success in removing the extra DNA, but this research is in the preliminary stages.[3]

Another potential mechanism for using cells such as skin cells to replicate the potential of embryonic stem cells is to reprogram adult cells in order to de-differentiate them back into pluripotent cells. A team of scientists from the University of Edinburgh's Institute for Stem Cell Research discovered that a gene known as "nanog" is key in the reprogramming process.[4] Identifying the other keys to reprogramming must be done before the de-differentiation approach will be a practical alternative to embryonic stem cells.

Research and Regulatory Environment

To date, no legislation has been passed in Texas that directly impacts skin cell research. Several federal initiatives have been considered that could affect skin cell scientists.

Senators Specter and Santorum, both Pennsylvania Republicans, filed the Alternative Pluripotent Stem Cell Therapies Enhancement Act, which would have required the National Institutes of Health (NIH) to promote research on creating embryonic stem cell lines without the destruction of human embryos. The bill, S 2754, was passed by the

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[2] C. Brownlee, "Turning Back Time," *Science News,* vol. 168, no. 9 (Washington, D.C., August 27, 2005) .
[3] Rick Weiss, supra note 1.
[4] Carl T. Hall, "A way around the dilemmas of stem cells," *San Francisco Chronicle* (June 15, 2006). Available: www.sfgate.com/cgi-bin/article.cgi?file=/c/a/2006/06/15/MNGRMJEGME1.DTL. Accessed: June 16, 2006.

Senate on a voice vote but failed to pass in the House.[5] The bill would have required the Secretary of Health and Human Services, after consultation with the NIH Director, to issue guidelines regarding the next steps required for additional research into the creation of pluripotent stem cells without creating, discarding, destroying or knowingly harming a human embryo or fetus. The Secretary would also have prioritized research with the greatest potential for near-term clinical benefit and would have had to consider input from the President's Council on Bioethics.[6]

In May 2005, the President's Council on Bioethics issued a report on alternative sources of pluripotent cells. This report highlighted the de-differentiation theory as a method for using cells such as skin cells to create pluripotent human cells. The Council concluded that, upon preliminary review, this was an ethically acceptable method of obtaining pluripotent cells and that the obstacles to the approach's medical utility were technical, not moral. The Council noted that research into de-differentiation was in the preliminary stages but that federal funding eligibility was likely for scientists conducting this research.[7] The NIH Stem Cell Task Force chair indirectly agreed with the Council's conclusion about federal funding by stating that the NIH did not need legislation in order to research methods of deriving stem cells that do not involve destroying human embryos.[8]

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[5] Major Congressional Actions, S 2754 (109th Congress, 2d Session). Available: http://thomas.loc.gov/cgi-bin/bdquery/z?d109:SN02754:@@@R. Accessed: July 23, 2006.
[6] United States Senate. S 2754, 109th Congress, 2d Session, 2006.
[7] President's Council on Bioethics, *Alternative Sources of Human Pluripotent Stem Cells* (May 2005). Available: http://www.bioethics.gov/reports/white_paper/fulldoc.html. Accessed: June 6, 2006.
[8] Kaiser Family Foundation, "NIH Official Says Legislation Not Needed for Agency to Research Means of Deriving Embryonic Stem Cells Without Destroying Embryos," *Kaiser Daily Women's Health Policy*

Emerging Technology Fund

Background

In recognition of the important role technology plays in today's society and in our economy, HB 1765 (79R) enacted the Emerging Technology Fund, a dedicated General Revenue account to be distributed through grants to expedite innovation and commercialization of research, attract or expand private sector entities that will promote an increase in high-quality jobs and increase higher education applied technology research capabilities. Eligible industries include medicine, biotechnology and life sciences. A 17-member committee is appointed by the Governor to recommend, through peer review and evaluation processes, grant recipients for approval by the Governor, Lieutenant Governor and Speaker of the House.[9]

The account was funded with $100 million from General Revenue, $100 million from the Rainy Day Fund and $25 million each for FY 2006 and FY 2007 to be reserved for the acquisition of research superiority grants.[10]

Implementation of HB 1765

Report (June 28, 2006). Available: http://kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=38171. Accessed: June 30, 2006.

[9] Texas State House of Representatives. House Bill 1765, 79th Legislature, 2005.

[10] Emerging Technology Fund. Available: http://www.governor.state.tx.us/divisions/ecodev/etf/index_html/view. Accessed: June 7, 2006.

Emerging Technology Fund grants have been given to five health-related projects. Texas Tech University received almost $2 million to further a partnership between the University and Bayer CropScience and help create the International Center of Excellence in Agriculture Genomics and Biotechnology.[11] Texas Tech is also using Emerging Technology Fund money in partnership with Lexicon Genetics of the Woodlands to work on assembling the largest collection of "knockout mouse" embryonic stem cells;[12] knockout mice have had a single gene removed for research purposes.[13]

Several health-related Emerging Technology Fund grant recipients were announced on May 31, 2006. CardioSpectra received a grant for $1.3 million. CardioSpectra has developed a device used to predict a patient's risk of heart attack known as the Optical Coherence Tomography Diagnostic Catheter. Xilas Medical obtained $1 million to help with the development of devices that help in early detection of neuropathies, foot stress and inflammation that can lead to diabetic ulcers and amputation. $500,000 was awarded to CorInnova for its Heart Therapy Device, a device that reduces by 60 percent or more the instances of congestive heart failure in patients who have had severe heart attacks.[14]

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[11] Office of the Governor, "Gov. Perry Announces Grant to Texas Tech for Agriculture Genomics Research," (Feb. 22, 2006). Available: http://www.governor.state.tx.us/divisions/press/pressreleases/PressRelease.2006-02-22.4318/view. Accessed: July 5, 2006.
[12] *Ibid.*
[13] Cindy Tunnel, "A&M goes high tech with 'knockout' mice," *San Antonio Express-News* (July 5, 2006). Available: http://www.mysanantonio.com/news/medical/stories/MYSA070506.1B.TAMUgenomics.126ebe0.html. Accessed: July 5, 2006.
[14] Office of the Governor, "Gov. Perry Announces $6 Million in Emerging Tech Fund Awards," (May 31, 2006). Available: http://www.governor.state.tx.us/divisions/press/pressreleases/PressRelease.2006-05-31.4951/view. Accessed: June 7, 2006.

Endothelix, Inc. won a later award of $1 million to use in the development of a medical device that generates more accurate and timely information about a patient's cardiovascular health by measuring vascular endothelial function through temperature changes in the patient's fingertip.[15]

Monebo Technologies, Inc. will receive $500,000 to help fund the commercialization of its new heart monitoring technology. The device allows patients to obtain their own electrocardiograms from home and transmit the results to their doctors wirelessly.[16]

$4.1 million was awarded to the University of Texas Health Science Center in San Antonio. The money will help create the Comprehensive Facility for Animal Imaging Research to allow scientists to evaluate new drugs and medical devices prior to and during human trials.[17]

Through these grants, the Emerging Technology Fund is helping ensure that Texas remains in the forefront in health-related research.

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[15] Office of the Governor, "Gov. Perry Announces $2.25 Million in Emerging Tech Fund Awards," (July 21, 2006). Available: http://www.governor.state.tx.us/divisions/press/pressreleases/PressRelease.2006-07-21.3449. Accessed: July 21, 2006.

[16] Office of the Governor, "Perry Announces $2 Million in Emerging Technology Fund Awards," (October 24, 2006). Available: http://www.governor.state.tx.us/divisions/press/pressreleases/PressRelease.2006-10-27.1508. Accessed: October 30, 2006.

[17] Office of the Governor, "Perry Announces $4.1 million For the University of Texas Health Science Center in San Antonio," (October 27, 2006). Available: http://www.governor.state.tx.us/divisions/press/pressreleases/PressRelease.2006-10-24.5029. Accessed: October 30, 2006.

Recommendations

1. **Continue the Emerging Technology Fund.**

   Rationale: The Emerging Technology Fund has helped encourage innovative technology research and commercialization in Texas and is key in maintaining Texas's position in the global market.

2. **Increase funding for the Texas Cord Blood Bank.**

   Rationale: Currently only four hospitals in Texas are collecting cord blood for the Texas Cord Blood Bank due to lack of funding for the collection and transportation of the blood. Increasing funding will ensure broader collection of cord blood.

Charge 6: Vaccination Rates and Supply

Study and make recommendations for improving vaccination rates and ensuring an adequate vaccination supply in the state. Include an analysis of vaccine manufacturing and purchasing policies.

Background

Immunizations are one of the top-ten high priority public health issues in the United States.[1] Within the public health community, vaccines are considered the best protection against childhood diseases and serve to protect individuals from acquiring infectious diseases. According to the National Immunization Survey (NIS) for 2005, Texas ranks 24th in the United States for immunization coverage nationwide, representing an 11 percent increase from the previous year. The NIS outcomes also show that 76.8 percent of Texas children ages 19 months through 35 months were fully vaccinated in the 4:3:1:3:3:1 vaccination series. This series contains four doses of diphtheria-tetanus-pertussis vaccine (DTP/DTaP), three doses of poliovirus vaccine, one dose of measles-containing vaccine, three or more doses of Hib vaccine (which can prevent meningitis and pneumonia), three doses of hepatitis B vaccine, and one dose of varicella vaccine.[2] Ensuring that children statewide, ages 15 months through 18 months, receive the fourth dose of DTP/DTaP on time is challenging, which may cause vaccination rates for individual vaccines included in the 4:3:1:3:3:1 series to be low. Yet, the increase in the

[1] Healthy People 2010. Leading Health Indicators: Priorities for Action. Available online at http://www.healthypeople.gov/lhi/factsheet.htm Accessed on 8-10-2006.
[2] Department of State Health Services. Annual Report on Plans to Increase Immunization Rates in Texas, September 30, 2006.

national ranking is evidence that strategic efforts toward increasing immunization rates throughout the state are having a positive impact.

A significant number of children throughout Texas are uninsured or underinsured. To ensure vaccinations are available and provided, the Department of State Health Services (DSHS) has directed many of its efforts toward evidence-based strategies targeted to increase vaccine coverage. Some of these efforts include the promotion of the medical home concept, the immunization registry, and the use of reminder/recall systems.

Medical Home

A medical home originates in a primary health care setting that allows for a partnership between the child, the family and the primary health care practitioner. Health care services needed by the child and the family may be accessed through the medical home. The provider community has long supported the medical home concept and believes it is an efficient and effective way to manage care and increase immunization rates.

Reminders and recall notices are part of the medical home concept and are generated by ImmTrac. Through this secure, web-based application, medical providers may generate a report to identify vaccinations that are due or overdue. This allows providers the ability to submit letters to parents reminding them to ensure their children are immunized on-time.[3]

[3] *Ibid.*

DSHS claims that while the medical home concept may be an effective strategy for increasing vaccination rates, it is more effective and complete when coupled with a statewide immunization registry. An immunization registry provides the capability to store and consolidate immunization records.

Immunization Registry

Texas' immunization registry, ImmTrac, is a confidential record-keeping system maintained by DSHS. In Texas, parents have the option to consent for their child's immunization records to be included in the registry. Parents may provide written consent during the completion of the birth certificate process or they may mail a completed Immunization Registry Consent form, along with any copies of immunization records at a later time. Once included in the registry, immunization records are then purged three months after the registrant's 18th birthday. If parents decide to withdraw consent, they must do so in writing, upon which all records will be deleted.

House Bill 1921 (78R) effective June 20, 2003, amended provisions of the Health and Safety Code relating to the immunization registry for children younger than 18 years of age. The bill required a one-time written consent for a child's inclusion into ImmTrac and prohibited DSHS from retaining identifiable information when consent is withdrawn.[4] This bill also required immunizations to be reported by providers and health plans. Consent must be verified by DSHS before information can be included in ImmTrac.

[4] Texas House Bill 1921, Bill Analysis, Enrolled Version, 78th Legislature, regular session (2003).

Immunization registries proved to be invaluable for preventing over-vaccination and resulted in a significant cost savings in the wake of the worst natural disaster to hit the United States, Hurricane Katrina. Due to the destruction caused by the hurricane, immunization records were lost. However, the Louisiana Immunization Network for Kids Statewide (LINKS) retained access to greater than 56,000 children's immunization records. Access to these records allowed millions of dollars to be saved in revaccination costs.[5] DSHS was able to verify 187,180 doses of vaccines already given and the City of Houston verified 87,203 doses, saving an estimated $4.2 million in revaccination costs, respectively.[6]

Seasonal Influenza Vaccine

Vaccines are the number one way to guard against the influenza virus, also known as the flu. More than 200,000 people are hospitalized and roughly 36,000 people die from influenza each year in the U.S.[7] Infection rates are highest among children and persons aged 65 or older and children less than two years of age comprise the highest rate of serious illness and death. The Centers for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP) provides recommendations and schedules the administration of vaccines in the U.S. Recently, the ACIP expanded influenza vaccine

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[5] Welch, Frank J., M.D. The Louisiana Immunization Network for Kids Statewide (LINKS) System and Hurricanes Katrina and Rita. ImmTech Strategies Summit presentation. Sponsored by St. David's Community Health Foundation. June 2006.
[6] Department of State Health Services, supra note 2.
[7] WebMD. Childhood Immunizations. Available online at http://www.webmd.com Accessed on 8-28-2006.

recommendations to include children ages six months to 59 months.[8] Due to influenza vaccine shortages that occurred during the last two flu seasons 2004 and 2005, efforts are underway to prevent future shortages. Shortages in the U.S. were due to manufacturing problems with one of the major influenza vaccine companies in which the company's license was temporarily suspended. This company was expected to produce approximately one-half of the vaccine supply in the U.S.[9] With concerns of shortages now easing, federal health officials expect a record 100 million vaccine doses to be available in the U.S. this flu season.[10]

The timeline for producing, manufacturing and distributing the vaccine is dependant upon the identification of all strains of the virus by the Food and Drug Administration's (FDA) Advisory panel, and the new strains of seed virus are supplied to manufacturers by the Centers for Disease Control and Prevention (CDC). The seed virus is typically supplied to manufacturers by February or March and shipments of the vaccine into the marketplace typically occur from September through November. Any disruption in this process could cause distribution delays.[11] The number of doses distributed is based off of historical data from previous seasons. During the 2002-2003 season, 95 million doses were produced of which roughly 83 million doses were used. For the 2003-2004 season, 87 million doses were produced; however, this supply was not enough. Several factors

[8]Centers for Disease Control and Prevention. Prevention and Control of Influenza. Recommendations of the Advisory Committee on Immunization Practices. Available online at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5510a1.htm Accessed on 7-28-2006.
[9]United States Government Accountability Office. Testimony Before the Subcommittee on Health and Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives. Available online at http://www.gao.gov Accessed on 8-20-2006.
[10]WebMD, supra note 7.
[11]Sanofi Pasteur, Testimony to the Texas Senate Committee on Health and Human Services (Austin, Tex, September 19, 2006).

may have contributed to this shortage, such as an earlier than expected, and more severe, flu season and increased vaccine awareness, via public education campaigns.[12]

Eight million doses are expected to be received in Texas during the 2006 influenza season. The majority will be distributed to the private sector for physicians and pharmacies. The Texas Vaccines for Children (TVFC) program will receive 400,000 doses and DSHS will have 110,000 doses provided as “adult safety net” doses.[13]

DSHS purchases the lowest priced vaccine for all vaccine purchases made within the department, including the influenza vaccine, when more than one vaccine with the same disease protection is available and the prices vary. If the prices are the same, DSHS purchases equal amounts of the vaccine from each manufacturer. The TVFC program allows providers to choose between single vaccines and newer combination vaccines.[14]

Pandemic Influenza

Public health experts are closely monitoring a specific type of virus called avian influenza, A(H5N1). Concerns center on a possible mutation of this strain causing sustained human to human transmission, resulting in a pandemic. The yearly influenza vaccination will not protect against a pandemic influenza virus. In the event of a pandemic, the virus would be used to develop the vaccine, resulting in a lag time

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[12] United States Government Accountability Office, supra note 9.
[13] Department of State Health Services, Testimony to the Texas Senate Committee on Health and Human Services (Austin, Tex, September 19, 2006).
[14] *Ibid.*

before the vaccine is available to the public.[15] Antiviral drugs for influenza may be in used in the meantime, but these agents are not a substitute for vaccination.[16]

The virus affects birds but humans who come into contact with infected birds are at risk. Although human cases are rare, there have been over 200 cases of infected humans reported to the World Health Organization (WHO) since September 28, 2006 (see table below). However, human infections were due to exposure to infected birds, not transmission from person to person. While there have been rare instances in which the virus was passed from one individual to another, to date, the virus has not mutated to cause widespread human to human transmission.[17]

Public health officials are developing preparedness plans in the event of a pandemic influenza virus. DSHS has been working with various stakeholder groups to develop a Texas Pandemic Influenza Plan to be submitted to the U.S. Department of Health and Human Services by February 1, 2007. This plan details Texas' intent on purchasing up to roughly 2.3 million additional antivirals.[18]

[15] Pan American Health Organization, Region Office of the World Health Organization. PAHA Strategic and Operational Plan for Responding to Pandemic Influenza. Available online at http://www.paho.org/English/AD/DPC/CD/vir-flu-PAHO-Plan-9-05.pdf Accessed on 9-5-2006.
[16] *Ibid.*
[17]CDC, supra note 8.
[18] DSHS, supra note 13.

Cumulative Number of Confirmed Human Cases of Avian Influenza A/(H5N1)[19]

Country	2003		2004		2005		2006		TOTAL	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
Azerbaijan	0	0	0	0	0	0	8	5	**8**	**5**
Cambodia	0	0	0	0	4	4	2	2	**6**	**6**
China	1	1	0	0	8	5	12	8	**21**	**14**
Djibouti	0	0	0	0	0	0	1	0	**1**	**0**
Egypt	0	0	0	0	0	0	14	6	**14**	**6**
Indonesia	0	0	0	0	19	12	49	40	**68**	**52**
Iraq	0	0	0	0	0	0	3	2	**3**	**2**
Thailand	0	0	17	12	5	2	3	3	**25**	**17**
Turkey	0	0	0	0	0	0	12	4	**12**	**4**
Vietnam	3	3	29	20	61	19	0	0	**93**	**42**
TOTAL	**4**	**4**	**46**	**32**	**97**	**42**	**104**	**70**	**251**	**148**

*Total number of cases includes number of deaths.
**WHO reports only laboratory-confirmed cases.

Human Papillomavirus (HPV) Vaccine

The Food and Drug Administration has recently approved a vaccine that may be given to females to prevent cervical cancer. Gardasil®, a vaccine manufactured by Merck, is the first FDA approved vaccine to prevent cervical cancer by guarding against genital human papillomavirus (HPV). Genital HPV infection is the most common sexually transmitted disease (STD) in the U.S. The vaccine protects against four types of HPV which together

[19] World Health Organization website
http://www.who.int/csr/disease/avian_influenza/updates/en/index.html Accessed on 10-02-2006.

cause 70 percent of cervical cancers and 90 percent of genital warts. The vaccine dosage requires three injections over six months and is estimated to cost $360.[20] The FDA recently licensed Gardasil® for females between the ages of nine and 26. In June 2006, the ACIP recommended for girls ages 11 and 12 to receive the vaccine. The vaccine is currently being studied for its effectiveness in males.[21]

Recommendations

1. **Increase the reimbursement amounts to providers for administering state vaccines through the TVFC program.**

   Rationale: The TVFC program is part of the Federal Vaccines for Children program. Through the TVFC program, providers are able to provide vaccines at no cost to program-eligible children. While these vaccines are available at no cost, providers incur storage facility, supplies and administrative costs. Provider groups contend their participation in the program is likely to rise should an increase in reimbursement rates occur.

2. **Prioritize health care facilities for receipt of seasonal influenza vaccines.**

   Rationale: Yearly vaccinations are recommended for persons at high risk of having serious flu-related complications or those

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[20] Centers for Disease Control and Prevention. HPV Vaccine. Available online at http://www.cdc.gov/nip/ACIP/default.htm. Accessed on 6-30-2006.
[21] *Ibid.*

who live with or care for high risk persons. The Centers for Disease Control recommends that seasonal influenza shots are offered when individuals are seen by their health care providers for routine appointments or as a result of hospitalization. In the event vaccine supplies are delayed during the flu season, policies for priority groups to receive the vaccine first have been developed. However, there is no prioritization required for distribution, which may be problematic for health care providers with high risk patients. While the ability for various entities to purchase large quantities of vaccines to provide seasonal influenza vaccinations to the general public offers a public health service, this practice may become problematic to health care facilities providing vaccinations to high risk persons because of limited supplies due to volume purchases from other entities. Establishing a policy for health care facilities to receive priority for receipt of seasonal influenza vaccines should enable providers to have an adequate supply of vaccines to serve high risk patients.

3. **Include adult and children vaccinations given during declared states of emergency into the state registry to allow for public health surveillance and to reduce duplication of vaccinations.**

Rationale: In light of recent natural disasters that hit the United States, the possibility of a pandemic influenza virus and the threat of unforeseen natural or man-made disasters, the use of a registry can be a tool for improved public health response. Tracking vaccination records through a state registry has been proven during Hurricane Katrina prevented duplication of vaccinations. During a declared state of emergency, adults and children who receive vaccines should be entered into the state immunization registry and vaccination records for children already opted into the registry should be updated. Records should be viewable by authorized users for public health tracking purposes during the event; and after a designated period of time upon conclusion of the emergency, records for adults and children who choose not to opt into the system should be purged.

4. **First Responders and their families should have the option to opt-in to the state registry to maintain vaccination records for public health tracking purposes and to prevent duplication of vaccinations.**

Rationale: First Responders receive vaccinations due to the nature of their jobs. During Hurricane Katrina, many responders received vaccinations before deploying to Louisiana and Mississippi to assist with rescue efforts; however, in the

event of another emergency, these records have not been maintained and the possibility for duplicative vaccinations exists. Use of a registry can help prevent duplication of vaccinations and ensure First Responders' vaccinations are up to date. The ability to opt-in to a registry should also be extended to family members of First Responders.

5. **Require vendors that sell electronic medical record systems in Texas to provide automatic record uploading and downloading capabilities for providers who serve the registry population.**

Rationale: HB 1921 (78R) required all health care providers to report, within 30 days of administering the vaccine, vaccines given to children younger than 18 years of age to DSHS. DSHS offers several ways for providers to report immunizations to the registry such as via the Internet, electronic data transfer from medical records software or through a paper reporting form for providers without computer access. Providers that elect to use an electronic data transfer system via electronic medical records software typically pay extra for report generating capabilities that include the fields necessary to populate the registry. Provider groups contend their participation in the registry may increase if electronic medical record systems included report generating

capabilities that include the fields necessary to populate the registry.

Charge 7: Nutrition and Physical Activity

Evaluate and make recommendations relating to the creation of a comprehensive and statewide nutrition and physical activity plan to address obesity and chronic diseases. Examine options for funding components of such a plan.

Definition of Terms

The terms obesity and overweight are used to indicate ranges of weight that are in excess of what is generally considered healthy for a given height. These terms also identify ranges of weight shown to increase risk for certain diseases and other health problems. Obesity is defined as an adult who has a body mass index (BMI) of 30 or higher. The Behavioral Risk Factor Surveillance System (BRFSS) found 63 percent of Texas adults were overweight or obese.[1]

For children, the term overweight is used by the Centers for Disease Control (CDC) to describe excess weight. For children ages 2-18, overweight is defined by a BMI at or above the 95th percentile by age and gender. At-risk-for-overweight is defined as BMI at or above the 85th percentile but less than the 85th percentile for age and gender.[2] Over 35 percent of Texas school-aged children are considered overweight. Overweight in children is problematic and costly as these children are at an increased risk for Type II

[1] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, and Behavioral Risk Factor Surveillance System. BRFSS Texas 2004. Centers for Disease Control and Prevention. Available online at http://apps.nccd.cdc.gov/brfss/. Accessed on 8-15-2006.
[2] *Ibid.*

diabetes and miss four times as much school as children of normal weight.[3] An average-sized school district loses $95,000 per year due to absenteeism among overweight students.[4]

Background

America has a serious obesity epidemic. Nearly two-thirds of American adults are either overweight or obese, 16 percent of children and adolescents ages 6-19 years are overweight,[5] and 31 percent are at-risk-for overweight.[6] Research has shown that overweight in childhood often continues into obesity in adulthood.[7] This is a critical public health concern with life-threatening consequences.

Numerous studies have shown a link between obesity and chronic disease risk. Heart disease, stroke and cancer are the top three leading causes of death in the United States and each are due to in part to obesity. Obesity also contributes to diabetes, the fifth leading cause of death. The prevalence of Type II diabetes, a disorder in which the body is resistant to insulin and does not properly respond to insulin or does not secrete enough insulin, is on the rise in both adults and children. This is a significant public health

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[3] Texas Department of State Health Services. Healthy Children, Healthy Schools. An Important Video for School Leaders. Available online at http://www.dshs.state.tx.us/phn/shac.shtm.
[4] *Ibid.*
[5] Trust for America's Health. F as in Fat: How Obesity Policies are Failing in America (2006). Available online at www.heatlhyamericans.org. Accessed on 9-26-2006.
[6] Strategic Plan for the Prevention of Obesity in Texas 2005-2010. The Texas Department of State Health Services. 2006.
[7] Clarke WR, Lauer RM. Does childhood obesity track into adulthood? *Crit Rev Food Sci Nutr.* (1993). Available online at http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=134463. Accessed on 8-28-2006.

concern, and one that may be prevented since a modifiable risk factor for Type II diabetes is overweight or obesity.[8]

Obesity has a significant impact on healthcare costs. Total costs including healthcare expenditures, loss of productivity and mortality was estimated in 2001 to be $10.5 billion. This estimate is projected to increase between $26 and $40 billion in the year 2040, assuming the Texas population continues to grow at its current rate.[9]

The Centers for Disease Control report that a sustained 10 percent weight loss will reduce an overweight person's lifetime medical costs by $2,200 - $5,300 due to lowering costs associated with hypertension, Type II diabetes, heart disease, stroke and high cholesterol.[10] It is estimated that if 10 percent of adults began a regular walking program, $5.6 billion in heart disease costs could be saved.[11]

Texas Legislative Efforts

77th Legislative Session

The obesity epidemic has raised concern among legislators and health and wellness stakeholders in Texas. Throughout several legislative sessions, laws have been enacted which have made significant strides toward the prevention of obesity.

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[8] Strategic Plan, supra note 6.
[9] *Ibid.*
[10] Centers for Disease Control and Prevention, The Problem of Obesity. Available online at http://www.cdc.gov/genomics/training. Accessed on 8-15-2006.
[11] Centers for Disease Control and Prevention. Obesity Factsheet. Available online at http://www.cdc.gov/nccdphp/publications/factsheets/prevention/obesity.htm. Accessed on 8-26-2006.

In 2001, Texas Legislature passed legislation that focused on decreasing the rates of overweight children by requiring comprehensive school health programs, physical activity and improved foods served on school campuses. Senate Bill 19 (77R) required students in kindergarten through sixth grade to participate in daily physical activity and required the Texas Education Agency to make coordinated school health programs available to each school district.[12]

Senate Bill 19 also established local school health education advisory councils within each school district to ensure local community values are reflected in the district's health education instruction. Coordinated school health programs must be available to all school districts and designed to prevent obesity, cardiovascular disease and Type II diabetes in elementary school students.[13]

78th Legislative Session

Senate Bill 1357 (78R) required school districts to make available for reasonable public inspection a statement of policies adopted to ensure elementary students engage in at least 30 minutes of physical activity per school day or 135 minutes per school week. The bill also required information to be made available for reasonable public inspection that must include the number of times the district's school health advisory council has met, whether the district has adopted and enforces policies to ensure restricted student access to vending machines, and whether the district adopted and enforces policies and procedures addressing penalties for the use of tobacco products on school campuses.

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[12] Texas Senate Bill 19, Bill Analysis, Enrolled Version, 77th Legislature, regular session (2001).
[13] *Ibid.*

Senate Bill 1357 also established more authority for the local school health advisory councils to recommend strategies for integrating school health services, counseling and guidance services, safe and healthy school environments, and school employee wellness.[14]

79th Legislative Session

The Texas Legislature expanded the physical activity requirement to include middle school students, during the 79th Legislative Session, by passing Senate Bill 42. This bill also required school districts to include health education as core curriculum, with the inclusion of diabetes education, from kindergarten through grade 12. It also mandates primary and secondary schools' food services to comply with Texas Department of Agriculture's foods of minimal nutritional value guidelines.[15]

Approximately 95 percent of all Texas schools participate in the National School Lunch Program, School Breakfast Program and the After School Snack Program. Schools participating in the federal nutrition programs adhere to a Public School Nutrition Policy that limits the number of grams of fat and sugar served to school children during the week. This policy also includes the gradual phasing out of deep-fat frying as a method for meal preparation. Schools not in compliance with this program are at risk of losing

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[14] Texas Senate Bill 1357, Bill Analysis, Enrolled Version, 78th Legislature, regular session (2003).
[15] Texas Senate Bill 42, Bill Analysis, Enrolled Version, 79th Legislature, regular session (2005).

federal reimbursement for all meals served for the period when policy violations occurred.[16]

House Bill 984 mandated a diabetes management and treatment plan for students with diabetes who may seek care during the school day or while participating in school activities. House Bill 984 also required training guidelines to be developed for unlicensed diabetes care assistants as well as a one-page information sheet for district employees responsible for providing transportation for or supervising a student with diabetes.[17]

Program Implementation Concerns

Statewide health and wellness stakeholders are concerned with barriers that impact a school district's ability to implement health education and physical activity requirements passed by the Legislature. Limited funding and competing educational priorities are challenges that impede many school districts statewide.

Comprehensive Statewide Nutrition and Physical Activity

Strategic Plan for the Prevention of Obesity in Texas: 2005-2010

Department of State Health Services (DSHS), in collaboration with statewide partners, has developed a strategic plan to prevent obesity in Texas. Partnerships include state and local governments, worksites, schools, child care centers, and the health care industry.

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[16] Texas Department of Agriculture, Texas Public School Nutrition Policy, Available online at http://www.agr.state.ts.us/foodnutrition/policy/food_nutrition_policy.pdf. Accessed on 8-10-2006.
[17] Texas House Bill 984, Bill Analysis, Enrolled Version, 79th Legislature, regular session (2005).

The strategic plan incorporates a myriad of strategies that may be implemented to support healthy behaviors.

Statewide and Regional Obesity Surveillance Data

DSHS oversees a childhood overweight surveillance project called the School Physical Activity and Nutrition (SPAN) survey. SPAN incorporates statewide and regional obesity surveillance data to assess the prevalence of child and adolescent overweight in 4th, 8th and 11th grade students.[18] SPAN data are based on BMIs calculated from measured height and weight rather than self-reported measures. Results indicate that the prevalence of overweight in children and adolescents is increasing. For example, study results conducted in a 1999-2000 National Health and Nutrition Examination Survey (NHANES) were used as comparative data for a SPAN study that assessed overweight prevalence within a particular grade. Study results showed SPAN survey data for overweight prevalence in girls and boys in the fourth grade were nearly 50 percent higher than the comparative study that targeted overweight prevalence in girls and boys within the ages of six to eleven.[19]

Priority Areas

Former Texas Commissioner of Health Dr. Eduardo Sanchez recommended six priority areas supported throughout the DSHS' 2005-2010 Strategic Plan to serve as the

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[18] Hoelscher DM, Day RS, Lee ES, et al. Measuring the prevalence of overweight in Texas schoolchildren. *Am J Public Health*. 2004; 94:1002-1008.
[19] *Ibid.*

foundation for a comprehensive statewide nutrition and physical activity plan and legislative initiative:

1) Increase surveillance efforts to assist with identifying overweight trends and community impact. This includes the continuation of SPAN data to track the obesity epidemic in school children and evaluate the effect of nutrition and physical activity interventions. SPAN surveys should include state-level surveillance and a selected number of county surveys.
2) Provide legislators with evidence-based data to assist with decision making. Included in the data should be measures of feasibility and sustainability, and impact on equity and stakeholders. Data relevant to the identification of unintended consequences of existing policies may also be helpful in deciding future initiatives.
3) Continue health promotion efforts targeted toward high schools.
4) Increase primary prevention programs at the community level and collaborate with faith-based organizations and other community based organizations to develop programs that meet community needs, and provide measurable return on investment data on community-based obesity prevention initiatives.
5) Model worksite wellness programs that show an impact on employee health and wellness to other public entities.
6) Develop primary prevention public awareness campaigns and public education programs. Studies have shown a relationship between behavior and education level. As more public awareness prevention programs are

designed, messages need to be targeted to meet specific community needs.[20]

Worksite Wellness Programs

Estimates of savings through worksite wellness programs range from $3.50 to $6.00 for each company dollar invested in the program. Medical cost increases were found in a study assessing Dallas City employees' annual medical expenses. Costs increased from $114 for normal weight employees to $573 for overweight and $620 for obese employees.[21]

Texas does not have a statewide wellness program; however, Department of State Health Services, Texas Department of Aging and Disability Services and the Department of Family Protective Services have instituted wellness programs. DSHS' program consists of four segments. The four segments include increasing employees' knowledge of their personal health status, consuming more nutritious food, increasing physical fitness and managing stress effectively.

To support these four segments, on October 17, 2005, DSHS began a pilot program called "personal health awareness." This pilot program was designed to improve employees' knowledge of their health and provided incentives to support them in their efforts. As of April 26, 2006, 29 percent or 3,453 employees had submitted an affidavit, signed by their physician, confirming they received a health risk assessment and related

[20] Sanchez, Eduardo, Presentation during the *Obesity in Texas: Policy Forum*. Sponsored by Texas Health Foundation. August 4, 2006.
[21] Strategic Plan, supra note 6.

screenings. DSHS' cafeteria also offered lower fat food choices in the main Austin campus to support healthier meal consumption.

Recommendations

1. **Consider a directive or incentive for state agencies to implement employee wellness programs.**

   Rationale: A strategy for addressing adult obesity prevention and incorporating daily healthy habits is to target efforts where adults spend most of their time, in the workplace. DSHS implemented a worksite wellness pilot program that may be used as a model and resource for other state agencies.

2. **Support additional state funding for coordinated school health programs and a statewide comprehensive obesity prevention and control program.**

   Rationale: Increased funding for coordinated school health programs and implementation of the department's strategic plan to prevent obesity should make a difference in the lives of Texas children and avoid the budgetary expenses involved with treating illnesses typically associated with obesity.

3. **Support additional state funding for a comprehensive, statewide tobacco prevention and cessation program.**

   Rationale: Increased funding for a comprehensive, statewide tobacco prevention and cessation program should make a difference

in the lives of Texas children and avoid the budgetary expenses involved with treating illnesses typically associated with tobacco use.

4. **Strengthen SB 42 (79R) by mandating physical activity in middle schools.**

   Rationale: Mandating the physical education requirement for middle school children should reinforce the importance and commitment for schools to provide physical activity and promote lifelong healthy behaviors.

5. **Require fitness assessments of all students, kindergarten through grade 12, to determine the impact of current efforts on academic achievement, absenteeism, obesity, discipline problems and school lunch programs.**

   Rationale: Studies have shown a correlation between physical activity and an increase in academic achievement. The adoption of a fitness assessment tool, used to track progress, should provide evidence-based information on health related outcomes for future comprehensive nutrition and physical education initiatives.

6. **Codify the Texas School Nutrition Policy into Texas law.**

   Rationale: Numerous studies have provided evidence for the positive association between cognitive and developmental benefits due to adequate nutrition. By placing the Department of

Agriculture's Texas Public School Nutrition Policy into law, these nutritional requirements will remain standardized and reinforce the state's commitment to a statewide, comprehensive nutrition policy.

7. **Leverage the state's role as a food purchaser to give preference to vendors that provide foods with higher nutritional value in public sector cafeterias.**

Rationale: As a food purchaser, government agencies have the power to require greater emphasis on nutritional value as a priority for contract bidding for foods served in public sector cafeterias. By offering healthy food choices, employees have access to nutritional foods that support health promotion and obesity prevention efforts.

Charge 8: Monitoring SB 6 Implementation

Monitor the implementation of SB 6, 79th Legislature, Regular Session, relating to Child and Adult Protective Services. Study and make recommendations for development and enhancements to protocols for joint investigations by child protective services workers and law enforcement and for interviews with children for disclosure of abuse.

Background

For much of the 2000s, the protective services system in Texas was in a crisis. High-profile child deaths across the state led to public outcry over the need for change. Governor Perry issued two executive orders in 2004 for the Inspector General to investigate both the Adult Protective Services (APS) and Child Protective Services (CPS) systems. The Senate Committee on Health and Human Services studied protective services extensively and made multiple recommendations in the Interim Report to the 79th Legislature.[1] The Governor designated protective services reform an emergency issue for the 79th Legislative Session, and Senate Bill 6 was the resulting omnibus protective services act. This report will update readers on the implementation of this legislation and outline areas that may need further review.

The 180 Day Progress Reports

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[1] Senate Committee on Health and Human Services, The Interim Report to the 79th Legislature, December 2004.

Senate Bill 6 requires that Health and Human Services Commission (HHSC) submit to the Legislature progress reports every 180 days after the effective date of the bill.[2] The first report was released March 1, 2006 and the second was later released in September 2006. The HHSC executive commissioner and the commissioner of Department of Family and Protective Services (DFPS) worked together to develop these reports and identified 24 reform initiatives. Highlights include:

Adult Protective Services

- Transferred guardianship from DFPS to Department of Aging and Disability Services (DADS) on September 1, 2005.
- Implemented a new APS risk assessment tool that improves the evaluation of a client's living condition, medical status, mental status, financial status and social support system.
- Hired 89 new APS staff, employed hiring specialists in each region and instituted a pre-screening and realistic job preview.
- Made an education stipend available to all APS staff. The stipend encourages caseworkers to attain a higher level of education in APS-related fields and promotes workforce retention.
- Assigned complex cases to experts in abuse, neglect and exploitation.
- Implemented new, comprehensive APS training that includes advanced training on mental health and self-neglect and emphasizes working with community organizations, law enforcement and courts.

[2] *Ibid.*

- Developed a new public awareness campaign, to begin in May 2006, which includes public service announcements and educational materials. Hired community initiative specialists in each region to oversee this campaign.

Children and Families

- Hired 1,778 CPS staff (caseworkers, supervisors, and clerical support staff) from September 2005 through June 2006.
- Developed a new investigative model, which includes a stronger risk assessment instrument, new screening procedures for lower priority cases and training to recognize and respond to high-risk cases.
- Hired 131 abuse and neglect special investigators and 51 child safety specialists to assist with CPS investigations and training.
- Expanded training for CPS caseworkers to include working with law enforcement, conducting forensic investigations, gathering evidence, upholding fourth amendment rights, writing affidavits and testifying in court.
- Implemented new processes to better screen job applicants to assess their ability to perform effectively in caseworker positions.
- Expanded the statewide kinship care placements since the inception of the Family Group Decision-Making model.
- Started pilot programs in Houston, Arlington and Fort Worth to address the disproportionate representation of minority children in the CPS system and, specifically, in foster care.

- Implemented continuous Medicaid coverage through a single application process until age 21 for youths who age out of foster care.
- Released a draft Request for Proposals for outsourcing substitute care services and a draft Request for Information for a comprehensive medical, behavioral health and dental network for the care of children in foster care.

Licensing and Regulation

- Adopted rules in December 2005 requiring background checks and drug testing in residential child-care operations.
- Implemented periodic, random inspections of DFPS foster homes and group foster homes.
- Strengthened minimum standards for residential child care facilities and child-placing agencies. The standards will be published in the *Texas Register* on September 8, 2006 and will be effective on January 1, 2007.[3]

Protecting Vulnerable Adults

Senate Bill 6 included multiple requirements to strengthen consistency of investigation practices and to provide better training and support for APS investigators. The Guardianship Program was transferred to DADS, as the expertise of its staff will better support the needs of the program and its recipients. A quality assurance program was developed with the statutory direction for client-centered outcome measures and

[3] The Texas Human Services Commission and the Department of Family and Protective Services, *Senate Bill 6 180 Day Progress Report,* March 1, 2006.

minimum job performance standards for APS employees. HHSC developed a risk assessment tool known as CARE to help investigators describe client problems and identify the risks. The training for APS caseworkers has been extended by four weeks to 11 weeks. Potential employees are pre-screened by hiring specialists to determine their capabilities. APS staff met with the Texas Higher Education Coordinating Board to help distribute a survey to Texas universities and colleges with social work departments asking whether they offer training necessary for a career at APS.

Caseloads within APS have been high over the past few years. Quality casework is difficult to produce when an investigator has a high caseload. Initially, 89 new employees were hired for the 2006-2007 biennium. However, since the Legislature passed Senate Bill 6, there has been a higher volume of intake APS calls which increased caseloads at much higher rate than anticipated. As a result, during this interim APS was authorized to hire an additional 179 caseworkers to help with the increased caseload. To help with case documentation, APS workers are now outfitted with tablet personal computers. These mini-computers allow for caseworkers to take pictures, type notes, and file information online to ensure for timely documentation of a case. This has made a significant difference in caseworkers' ability to work effectively.

Protecting Children

Strengthening CPS Investigations

Senate Bill 6 made multiple reforms to help strengthen CPS investigations. One such reform encourages co-location of law enforcement with CPS investigators at child

advocacy centers to encourage better cooperation between the two agencies. Training of CPS caseworkers has increased from six weeks to three months and they are now required to receive training in forensic methodology. CPS investigators are also mandated to receive joint training with law enforcement to strengthen collaboration. CPS has contracted with the Shaken Baby Alliance to provide some of the joint training.

DFPS has developed a new investigative structure based on directives from Senate Bill 6. A separate division dedicated solely to investigations has been created, and it's the new director has a background in law enforcement. DFPS has hired over 121 special investigators to help caseworkers with the more serious abuse cases. These investigators are also required to have a law enforcement background.

Senate Bill 6 requires a more timely response to reports of abuse and neglect. There is a mandated 24-hour response time for Priority 1 cases and a 72-hour response time for Priority 2 cases. These new requirements are tough to accomplish because of the high intake of cases. In order to determine the best response methods, DFPS initiated a pilot in Dallas/Fort Worth and surrounding counties, using a five day response time for Priority 2 cases. After reviewing this pilot, DFPS plans on implementing another pilot with the 72-hour requirement. The full implementation of these requirements is set for September 2007.

DFPS has hired case screeners and child safety specialists to help with better detection and screening of cases. Intake workers assign Priority 2 cases to screeners for review

before an investigation takes place. These screeners make initial background checks and search for case history within 72 hours. Using screeners for lower priority cases has helped caseworkers with their workload. Screeners are able to cull cases that do not need investigating and reprioritize cases that need a quicker response from investigators. From January 2006-May 2006, screeners have reviewed over 19,000 reports and were able to close almost 25 percent of those cases.4 Child safety specialists were also hired to help with risk assessment training. These specialists are dispersed among the field offices to help caseworkers in their investigations and risk assessments.

Concerns for Investigations

DFPS has contracted with one provider for joint training and is also in the process of directing regional law enforcement liaisons to work locally to provide joint training with law enforcement. Law enforcement officers in certain regions have expressed that this has been a slow process and that they have had difficulty accessing training. Also, during the initial hiring of the special investigators, there was confusion over their role within an investigative unit. Many of these special investigators felt that they should be licensed peace officers and be able to carry a gun. Others have suggested that DFPS should have the option of either internally hiring special investigators or contracting out with local law enforcement when special investigative services are needed in the more difficult cases.

[4] Department of Family and Protective Services, *Presentation to the Partners in CPS Reform Meeting*, August 2006.

Another concern among advocates is the need to expand the drug endangered child initiative to include other harmful drugs. Senate Bill 6 requires that DFPS establish a drug endangered child initiative for children exposed to methamphetamine or children who are exposed to the chemicals it takes to make this drug. These cases are considered Priority 1 cases. CPS has collaborated with the Texas Alliance for Drug Endangered Children to help develop new protocols to help the agency with these cases.

Support for Quality Casework

Due to high caseloads and the inherent stress of witnessing the effects of child abuse, CPS caseworkers have traditionally had very high caseloads and combined with a high-stress work environment, CPS has been plagued with high turnover of caseworkers. Since Senate Bill 6 implementation, CPS has hired over 2,000 direct delivery staff.[5] Although the agency has hired over 636 investigative caseworkers since August 2005, over 495 investigators have quit within the same time-frame.[6] This high turnover caused strain within the agency because of the high inexperience of many of the frontline workers. Average daily investigative caseloads are down from 43.2 in FY 2005 to 30.7 in FY 2006. This caseload drop occurred even after a four percent increase in CPS investigation calls to intake.

Caseloads have decreased not only because of hiring new staff, but also because the agency has implemented a new system of workload distribution. This system is called a functional unit. Each unit consists of five caseworkers and one supervisor. Each

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[5] Texas House Human Services Committee, Testimony given by Commissioner Cockerell of DFPS, August 8, 2006.
[6] Garrett, Bob, *CPS Lags on Staffing Requirements*, Dallas Morning News, September 23, 2006.

functional unit will have both a case-aide and a clerk which will assist caseworkers in their daily clerical duties. These new employees have decreased the workload duties of caseworkers and allowed them to focus on investigations or permanency goals for the children. Decreasing the ratio of supervisors to caseworkers helps create a better support system for caseworkers.

In addition, DFPS has enacted new hiring techniques that aid in recruiting the best qualified applicants. The agency utilizes hiring specialists to help pre-screen applicants. A behavior interview guide and test is also given to assess the applicant's ability to respond to real life situations in the high stress protective services environment.

The 79th Legislature appropriated additional funds to DFPS for the purchase of new technologies to help caseworkers produce more accurate case documentation. Tablet PCs are currently being distributed and CPS investigators also have access to a mobile dictation service. Both services assist caseworkers in a timelier processing of cases.

Concerns about Caseworkers and Caseloads

Although investigative caseloads have decreased, conservatorship caseworker caseloads have actually increased. As of September 2006, the average daily caseload for a conservatorship caseworker was 44.2; this is up from the September 2005 average of 42.6.[7] Appropriations during the 79th Legislative Session authorized the agency to hire more investigative caseworkers, but not conservatorship workers. During this interim,

[7] Department of Family and Protective Services, *Written Testimony on Implementation of SB 6 to the Senate Committee on Health and Human Services*, November 14, 2006.

HHSC transferred monies to DFPS to hire an additional 100 conservatorship caseworkers to help with the increased workload. While this has helped, DFPS has continued to see an increase in caseloads. Complaints have also been made because conservatorship caseworkers did not receive a pay raise while investigative caseworkers received a $5,000 raise.

Retention of qualified staff continues to be a problem for the agency. The staff turnover rate for third quarter 2006 is 28.9 percent, down from the 2005 rate of 29.3 percent.[8] Stress and a pay scale that is typically lower than average teacher salaries are commonly mentioned as contributors to high turnover rates.

Support to the Family

Many of the reforms in Senate Bill 6 were intended to support the family. Best practices have long stated that children often have better outcomes when they are placed in the care of relatives. The bill required the development of a Relative or Other Designated Caregiver Program that supports placement of children with kin. DFPS enacted rules in December 2005 to support this program and the requirement to provide an initial payment of $1,000 per sibling group and an annual recurring $500 per child to qualified kinship caregivers. This support helps the caregiver pay for the initial start-up costs of caring for the children. To aid caregivers and parents, DFPS was required to develop a manual that provides resource and contact information for the parent or relative caregiver. Furthermore, a child placement resource form will now be given to parents

[8] The Health and Human Services Commission and the Department of Family and Protective Services, *The Second 180 Day Progress Report*, September 2006.

when their child must be removed from the home. This form asks the parents to provide three potential kinship caregivers for their children. DFPS is then required to conduct a background check and written home assessment on the most appropriate person on the form before the first adversarial hearing. More placement options for children will be available to the agency with the use of the child placement form.

Another program showing very positive results is the Family Group Decision Making Program. This program provides a process for engaging family members in decision-making for the children and developing a service plan for use as needed throughout the case.[9] The program began as a pilot in three counties and has now been implemented in over 80 counties. It has assisted with identifying relative caregivers, addressing families' needs and increasing family reunifications.

In addition, Senate Bill 6 also added new requirements for ad litem attorneys that are appointed to represent the children and parents. These ad litems are now required to meet with a child and their caregiver(s) before each court hearing unless the court finds it not feasible. Ad litems are also now appointed to indigent parents earlier in the process, at the time the State asks for temporary managing conservatorship.

Concerns about Family Initiatives

Many relatives would like to care for children but are unable to because of money constraints. Some have expressed that, with more state assistance, relatives could be the

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[9] The Health and Humans Services Commission and The Department of Family and Protective Services *Senate Bill 6 180 Day Progress Report*, March 1, 2006.

best option for displaced children. Others believe that the Family Group Decision Making Program should be expanded from its current presence in 80 counties. Still others believe the program places additional strains on caseworkers, some of whom report that it is difficult to find time for the extensive preliminary checks required for placements with relatives, especially when caseloads are high. Some counties have commented that the new ad litem requirements are an unfunded mandate. Others disagree that it is necessary to provide ad litems to parents at the earlier time.

Raising Licensing Standards

Senate Bill 6 enacted multiple reforms to the child care licensing division at DFPS. Some of the additional requirements include higher educational requirements of child placing agency administrators, new reporting guidelines and investigating of child-on-child abuse, and revising the definition of what is considered a serious incident in a residential child care operation. There is for residential facilities to conduct background checks on all employees who have direct access to a child and these checks must be completed before the employees are hired. Along with new background check requirements, each residential facility must have a drug-testing policy. CPS inspectors will now periodically inspect a random sample of foster homes and group homes to make sure children live in safe environments. This piece was fully implemented in April 2006, and in the future, 30 percent of the foster homes will be monitored annually.

In addition to the changes required in Senate Bill 6, DFPS is in the process of making major revisions to the minimum standards for residential child care and minimum

standards for child placing agencies. Since January 2003, the agency has held extensive stakeholder meetings to discuss best practices and needed revisions to the standards. These revisions were published in the *Texas Register* on September 8, 2006 and will take effect on January 1, 2007. The Senate Bill 6 licensing requirements will be incorporated into these minimum standard revisions.

Adam Walsh Child Protection and Safety Act

In July 2006, the federal government passed the Adam Walsh Child Protection and Safety Act. As of October 1, 2006 all prospective foster or adoptive parents and all adult residents (18 years or older) of a prospective home must complete a fingerprint-based National Crime Information Center criminal history check (FBI check), and for applicants/adults in the home who have lived out of state in the last five years, a check of the other states' central registries for abuse and neglect. These new requirements do not extend to existing foster and adoptive parents.[10]

Concerns about Licensing

Child placing agencies and residential child care facilities have expressed that the revised minimum standards will cost additional money to implement. Some also contend that the current rates do not reflect the raised standards, and believe that they will go out of business without an increase to rates. Also, although Senate Bill 6 mostly addressed licensing for residential child care, some revisions also incorporated licensed day care

[10] The Department of Family and Protective Services News Available at: http://www.dfps.state.tx.us/about/news/2006/2006-10-14_federal_ccl.asp. Accessed: November 14, 2006.

facilities. Recent child deaths in Dallas-area day care centers have highlighted the need for reform to child care centers.

Outsourcing for Better Outcomes for Children

Senate Bill 6 directs the agency to outsource all substitute care and case management functions of the agency by September 1, 2011. This is to occur incrementally and the bill sets a timeline for completion. The goal of outsourcing is to provide a new structural model for the community-centered delivery of substitute care and case management services that is based on improving protective services, achieving timely permanency for children in substitute care (including family reunification, placement with a relative, or adoption), and improving the overall well-being of children in substitute care consistent with federal and state mandates.[11]

Since the passage of Senate bill 6, the agency conducted extensive research on outsourcing. The agency developed and released a strategic plan on outsourcing in October 2005 and released a more extensive transitional plan in March 2006. It established a project team made up of experts within the agency and HHSC to help develop and implement the plan. This project team researched other states' privatized systems and met regularly with stakeholders. A Request for Proposal was released in May 2006 for an independent administrator for the first outsourced region. After the announcement that Region 8 (Bexar County and 27 surrounding counties) will be the first outsourced region, an advisory committee of stakeholders was established. This advisory

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[11] The Health and Humans Services Commission and The Department of Family and Protective Services *Senate Bill 6 180 Day Progress Report*, March 1, 2006.

committee will provide input to the multi-disciplinary team regarding concerns of stakeholders during the transition.

The outsourcing of substitute care and case management will occur over multiple legislative sessions. Much of the preliminary planning has already occurred, however there is still much work to be done. It is important that the Legislature continue to monitor the progress of outsourcing and to make legislative adjustments if needed throughout this process.

Outsourcing Transition Timeline[12]

Tentative Award contract for Independent Administrator (IA) in 1st Region	September 20, 2006
Award contract for Independent Evaluator	September 30, 2006
Complete transition of services in 1st Region	December 31, 2007
Multi-disciplinary team's annual report due	December 31, 2007
Independent Evaluator's report due on 1st region	December 31, 2008
Multi-disciplinary team's annual report due	December 31, 2008
HHSC report due on needed modifications	December 31, 2008
Complete transition of outsourcing in 2nd and 3rd regions	December 1, 2009
Multi-disciplinary team's annual report due	December 31, 2009
Independent Evaluator's report on 2nd and 3rd region	September 1, 2010
Multi-disciplinary team's annual report due	December 31, 2010
HHSC report due on any needed modifications	December 31, 2010
Complete the transition of services statewide	September 1, 2011

[12] The Health and Humans Services Commission and The Department of Family and Protective Services *Senate Bill 6 180 Day Progress Report*, March 1, 2006.

Concerns About Outsourcing

In September 2006, the agency indefinitely delayed awarding a contract for the Independent Administrator for the first outsourced region. At the time of this report it is unknown what the agency's next step will be. Because of the delay, the statutory timeline for outsourcing might need to be adjusted. Many providers and child placing agencies have expressed are concerns that with the use of an independent administrator, there will not be adequate funding for direct services to children. If this is not adequately funded, they fear that outsourcing will not be successful nor will it achieve better outcomes for children. Additionally, some stakeholders are concerned about the process of court proceedings under the privatized model. They are concerned that a privatized caseworker will be ill equipped to handle these new duties. Stakeholders are also concerned that because the agency is ultimately responsible for the child's welfare, they must continue to have a role in the court proceedings. Some are concerned that there might not be adequate monitoring of the independent administrator and child placing agencies under the new system. Challenges in the implementation of integrated eligibility have increased fears that there might be similar problems with outsourcing in CPS.

Improving Medical Care

Senate Bill 6 requires that HHSC develop and implement a statewide healthcare delivery model for foster children to provide them with more comprehensive medical care. HHSC released a Request for Proposal for the new medical managed care model in July, 2006. This model will create a system ensuring each child will have a primary physician to coordinate care.

Parents who have not lost their parental rights will be informed when their child has a significant medical condition. Each child will now have a medical passport that will help to fully inform doctors about the medical care of that child. This bill also requires medical consent for children in foster care. Consent can be obtained from a parent, foster parent, or CPS caseworker. Medical consenters will have the option of choosing a primary care physician who best fits the needs both the child and the consenter.

DFPS is currently negotiating with the University of Texas Health Sciences Center to develop a forensic assessment network.[13] This network will utilize pediatric centers of excellence that specialize in forensic assessments, diagnoses, and treatments of child abuse and neglect. Along with these centers, there will be a telemedicine link to rural areas.

HHSC and DFPS released guidelines to doctors on best practices and uses of psychotropic medication in children. Five months after the release of the guidelines, a study was conducted and it reported the prescribing of psychotropic medications to foster children dropped by seven percent, and there was also a drop of 29 percent of foster children who were prescribed two or more psychotropic medications in the five months after the release of the guidelines.[14]

Concerns About the Medical Model

[13] The Health and Humans Services Commission and The Department of Family and Protective Services Senate Bill 6 180 Day Progress Report, March 1, 2006.
[14] *Ibid.*

Child placing agencies are concerned that their specialists on staff at therapeutic treatment facilities might have conflicting opinions with treatment guidelines under a managed care model. Foster children often need more extensive, higher-priced care than the children outside the system. Providers worry that under a managed care model, they will have problems with reimbursements. Stakeholders are also concerned about coordination between this new medical model and the new outsourced system.

Another concern expressed by some is that although HHSC has hired a child psychiatrist to research foster children's Medicaid prescription data and some cases show possible signs over over-prescribing or misdiagnosing children, no further investigation is planned with these individual cases. Stakeholders were also very concerned during the early stages of implementation of medical consent that there was not enough education for doctors and foster parents to assist in the transition. DFPS has developed an online guide to medical consent and has participated in forums to help with the education.

Additional concerns address the serious mental illnesses that affect many foster children who have suffered traumatic experiences. Once these children are stabilized in a psychiatric hospital they no longer meet "medical necessity" criteria for acute hospitalization, but they are not stable enough to return to the community. Currently, Texas does not have psychiatric treatment hospitals for children that need sub-acute care and many foster families and residential treatment facilities do not have the expertise to address their high needs.

Disproportionality

Senate Bill 6 directed HHSC and DFPS to determine whether CPS enforcement actions are disproportionately initiated against any racial or ethnic group after accounting for other relevant factors. The first report released in January 2006 addressed whether or not there was significant disproportionality in the system. The study reported that even when taking into account other relevant factors such as age, sex of the victim, family income, allegation type and martial status, there was a significant overrepresentation of African Americans. Since the release of the first report, both HHSC and DFPS worked together to develop a plan to address the findings. Although most of their policies were found to be reasonably sound, they made revisions where necessary.[15]

Many policies mandated by SB 6 have made significant strides towards addressing disproportionality. These policies:

- Mandated cultural awareness training and targeted recruitment for both foster/adoptive parents and caseworkers. DFPS revised training for new caseworkers and is working on updating training for current staff. DFPS has also targeted recruitment for adoptions among faith-based organizations including One Church One Child and Congregations Helping in Love and Dedication (CHILD).
- Expanded Family Group Decision Making: This program, which was touched on earlier in this report, helped increase the percentage of

[15] The Department of Family and Protective Services, *Disproportionality in Child Protective Services: Statewide Reform Begins with Examination of the Problem,* Available: http://www.dfps.state.tx.us/Documents/about/pdf/2006-01-02_Disproportionality.pdf. Accessed: July 1, 2006.

African American children returning home from 32 percent as compared to 14 percent in families that did not participate in a conference. Tarrant County is a new pilot site to train African American community members to help facilitate Family Group Decision Making conferences.

- The kinship care manual, resource form, $1,000 start-up assistance per sibling-group placement and $500 annual recurring payment per child for qualified caregivers increased placement options for CPS by helping to identify relative caregivers. This is expected to positively affect the rate of relative placements and adoptions among minorities.

Other Remediation Steps include:

- Reviewing the process in which caseworkers and supervisors make case decisions to evaluate whether there is a race bias when making decisions.
- Developing collaborative partnerships between external community stakeholders and DFPS. Two Community Advisory Committees were established in Harris County and in the Metroplex. The committees are charged with communicating concerns and recommending changes to help with the disproportionality.

Concerns with Disproportionality

HHSC and DFPS believe that more professional research is needed to determine whether race and ethnicity play a role when caseworkers evaluate risk. This research will be supported through a partnership between state agencies, foundations and academic institutions. HHSC and DFPS are pursuing the needed resources to conduct this research.

Other Concerns with Senate Bill 6 Reforms

Harris County Attorney Mike Stafford requested an opinion in April 2006 from the Attorney General as to whether DFPS or an independent administrator may contract with a governmental entity to provide substitute care and case management services. Harris County Protective Services for Children and Adults provides over $4.7 million of support services for the benefit of children and families who are clients of the Department of Family and Protective Services. These value-added services, intended to prevent the need for more expensive longer-term services and produce better outcomes for children, are in addition to those provided by DFPS to children in substitute care.[16] In opinion # GA-0476, General Abbott stated:

> *Under the terms of Senate Bill 6, Seventy-ninth Legislature, the Department of Family and Protective Services may not contract with a governmental entity for the provision of substitute care and case management services except for emergency services or as a service provider of last resort. In a region that has an independent administrator to procure substitute care and case management service providers, the independent administrator may not contract with a governmental entity to provide such services. Notwithstanding*

[16] Harris County Attorney Mike Stafford, *Opinion Request Letter# 0475- GA*, April 13, 2006.

> *the privatization of substitute care and case management services, a governmental entity may continue to provide community services to the extent authorized by other law.*[17]

Under this ruling, Harris County will no longer be able to provide substitute care and case management services under privatized model set forth in Senate Bill 6. Harris County can continue to provide these services until the region is selected to be privatized under the regional rollout timeline.

Another concern brought by Harris County, was whether Government Code section 51.961(g), which requires one-half of the family protection fee collected in divorce suits to be deposited in the child abuse and neglect prevention trust account, violates the open courts provision, Texas Constitution article I, section 13.[18] In opinion # GA-0387, General Abbott stated:

> *Government Code section 51.961(g), as amended by the Seventy-ninth Legislature, requires one-half of a fee collected in a suit for dissolution of marriage to be deposited to the credit of the child abuse and neglect prevention trust fund account, which is used to fund child abuse and neglect prevention programs carried out by the Department of Family and Protective Services. Pursuant to the open courts provision of the Texas Constitution, article I, section 13, filing fees may only be used for judicial support services.*

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[17] Attorney General Greg Abbott, Opinion #. GA- 0476, October 30, 2006.
[18] Harris County Attorney Mike Stafford, Opinion Request Letter # 0362- GA, July 8, 2005.

Section 51.961(g) allocates filing fees to purposes other than judicial support services and therefore imposes an unconstitutional burden on a litigant's right of access to the courts in violation of article I, section 13.[19]

Recommendations

1. **Expand the Drug Endangered Child Initiative to include other substances given Priority 1 status such as cocaine, crack and heroin.**

   Rationale: Children in homes where drugs are used are often times in very dangerous situations. By including other harmful drugs to this initiative, these cases will be prioritized by giving them the Priority 1 status and lead to better safety for children. The agency has made great strides in protecting children that are in methamphetamine environments, however, they should prioritize other children that are exposed to other similarly harmful drug environments.

2. **Require the Department of Assistive and Rehabilitative Services (DARS) and DFPS to work together to help improve the care of hearing impaired children and to recruit more deaf and hard of hearing foster/adoptive parents.**

   Rationale: Many hearing impaired foster children are not being cared for by someone who can communicate using sign language.

[19] Attorney General Greg Abbott, Opinion # GA-387, December 28, 2005.

These children are often times kept in residential treatment facilities for the simple fact that the agency has not been able to find a foster home for them. A child cannot thrive if they cannot communicate. These agencies should strive to find additional foster and adoptive families that can better assist children with these special needs.

3. **Strengthen joint investigations between law enforcement and CPS by allowing CPS to contract for special investigator services.**

Rationale: Currently, CPS employs special investigators to handle cases involving high priority abuse cases. In some areas of the state, it might be more beneficial for the agency to contract directly with law enforcement to handle these cases.

4. **Provide family members who are potential adopters with family group counseling for children.**

Rationale: Senate Bill 6 called for an expansion of the Family Group Decision Making Program. This program should be extended to potential kinship adopters to assist them through the transition.

5. **Research ways to increase retention of caseworkers.**

Rationale: CPS continues to struggle with retaining experienced caseworkers. This field will always be stressful, however; DFPS should continue to study ways to encourage staff to

stay with the agency, including the possibility of increasing salaries or providing bonuses, and continue to hire additional staff to help lower caseloads. Special attention should be given to the conservatorship divisions that have the highest caseloads.

6. **Fully-fund evidence-based child abuse prevention programs.**

Rationale: During this budget cycle, agencies were asked by the Legislative Budget Board and the Governor to decrease their baseline budgets by ten percent. This decrease does not include entitlement programs which include foster and adoption programs. The DFPS Legislative Appropriation Request takes the entire ten percent cut in prevention services. This represents a decrease in over 53 percent of the entire prevention budget. Early recognition and treatment of at-risk youth helps to prevent child abuse and reduce the number of incarcerations. Many of these programs have proven to generate positive outcomes and, in the long run, they will save the state money.

7. **Develop a cross-reference database system between CPS and private agencies for checking the backgrounds of foster and adoptive parents.**

Rationale: Some potential foster parents or current foster parents currently are able to agency-hop between various private child placing agencies. A system needs to be put in place

so a Child Placing Agency (CPA) can check on the previous history of a potential parent and report unsavory or fraudulent activities.

8. Incorporate policies that reflect best practices for infant and toddlers.

Rationale: It is important that infants and toddlers receive very thorough therapeutic care while in the protective services system. Removing a child so early in their life can be traumatic and it can also affect the child's brain development. Infants and toddlers should be placed with pre-screened adults who can not only provide a safe environment for the child but also be emotionally available to them. Also, visitation for infants and toddlers should be a therapeutic part of a plan for reunification to help families address issues that led to the removal. Relevant professionals should be included in planning for reunification. Following best practices in early child development will contribute to better outcomes for these young children.

9. Create a state review committee on licensing standards.

Rationale: DFPS has worked diligently to improve care by revising the minimum standards for child placing agencies. The agency has also hired additional licensing staff and improved training procedures. Unfortunately, they are still

plagued with horror stories about certain facilities and foster parents. Creating a permanent committee on licensing standards provides a forum for Child Placing Agencies, foster parents, and community advocates to come together to develop and discuss best practices. This committee should include both public and private members and be required to review data and make recommendations on needed improvements.

10. **Provide sub-acute care for CPS children leaving acute psychiatric hospitals by creating a step-down care for foster children leaving psychiatric hospitals.**

Rationale: The agency should create a license for psychiatric residential treatment facilities (PRTF). Treatment can be reimbursed by Medicaid, and currently Texas is one of only three states that does not have issue this license. In other states, PRTFs' intensity of treatment and the level of payment are between the current reimbursement and acute psychiatric hospitalization. Creation of this level would enable providers (hospitals, RTCs, shelters) to provide the intensity of services needed and increase the children's likelihood of staying in the community and out of the juvenile probation system.

Charge 9: Use of the 2-1-1 Network

Study the current use of the 2-1-1 network and provide access to information on federal, state and local resources. Examine and make recommendations on strategies that improve the coordination of service information and expand the availability of information on services currently provided by community and faith-based organizations.

Background

In 2004, roughly, 13 percent of the United States' population, or 37 million people were living in poverty across the nation.[1] Texas statistics show that 16 percent of our state's population lived below the federal poverty level in 2002.[2] The need for human services continues to grow, and as our nation becomes more technologically advanced, opportunities to enhance coordination of human services on a local, state, and national level become more realistic.

Connecting people to local services was the basis for the development of the 2-1-1 system. Many state and local governments had information and referral systems already in place before the development of 2-1-1, but these differing systems lacked coordination and had varying professional standards. The first 2-1-1 system was developed in 1997 by the United Ways of Metropolitan Atlanta. 2-1-1 is a one stop referral phone system that connects people in need to local health and human services in their area.

[1] U.S. Census Bureau, *Income Stable, Poverty Rate Increases, Percentage of Americans Without Health Insurance Unchanged*. (August 2005) Available: http://www.census.gov/Press-Release/www/releases/archives/income_wealth/005647.html. Accessed: August 9, 2006.
[2] U.S. Census Bureau, *March 2003 Current Population Survey for Texas*. Data Analysis done by The Research Department of Texas Health and Human Services Commission.

In July 2000, the Federal Communications Commission (FCC) officially designated 2-1-1 as the national health and human service number.[3] It was further endorsed when, on June 12,2002, President Bush signed into law the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Public Law 107-188), authorizing state block grants and establishing 2-1-1 as an allowable use of funds.[4] To date, 2-1-1 has been implemented in 39 states, the District of Columbia, Canada, and Puerto Rico. It serves over 172 million Americans. Although each state system works independently, 2-1-1 is a public/private partnership between local community-based organizations, such as the United Ways and respective state governments. Funding for this system comes from community foundations, and federal, state and local governments.

2-1-1 Texas

The Information and Referral Network Division of the Texas Health and Human Services Commission established and maintains the 2-1-1 Texas system. Statutory authority was granted in House Bill 2596 (75R) and House Concurrent Resolution 109 (77R).[5] In April 2001, the Public Utility Commission of Texas amended rule 26.127 to assign HHSC the responsibility for implementing 2-1-1 in Texas. Today, 2-1-1 Texas has a total of 25 area information centers (AICs) which are active in the following regions: the Gulf Coast

[3] Ray Marshal Center for Study on Human Resources at the LBJ School of Public Affairs, *The Value of a Comprehensive Texas Information and Referral Network*: (August 2000).
[4] Ray Marshal Center for Study on Human Resources at the LBJ School of Public Affairs, *National Benefit/Cost Analysis of Three-digit Accessed Telephone Information and Referral Service Final Report:* (December 2004).
[5] Texas House of Representatives, House Bill 2596 and House Concurrent Resolution 109, 77th Regular Session.

(Houston), Southeast Texas (Beaumont), South Central Texas (Austin), North Central Texas (Dallas and Fort Worth regions), Panhandle (Amarillo), Bryan/College Station, Tip of Texas (Weslaco), Texoma (Sherman), Permian Basin (Midland), Central Texas (Belton), Alamo (San Antonio), Coastal Bend (Corpus Christi), Heart of Texas (Waco), North East Texas Region (Sulphur Springs), North Texas (Wichita Falls), West Central Texas (Abilene), Golden Crescent (Victoria), East Texas (Tyler), Concho Valley (San Angelo), Deep East Texas (Jasper), South Texas (Laredo), Middle Rio Grande (Carrizo Springs), Rio Grande (El Paso), and South Plains (Lubbock) (see Appendix A). Most of these regions use the councils of government boundaries as their boundaries, with a few exceptions. These AICs are operated by individual agencies including United Ways, area agencies on aging, local workforce boards and private non-profits. Each AIC maintains a comprehensive regional database which must be continuously updated and have an annual formal fact check update.

In order for a local AIC to become a part of the 2-1-1 Texas network, they must first be certified by the Alliance of Information and Referral Systems (AIRS). AIRS is the credentialing authority behind both an accreditation program that measures an organizations' ability to meet the AIRS standards and a certification program that evaluates the competency of information and referral practitioners. [6] AIRS has a membership of over 1,000 information and referral organizations across the U.S. and Canada.[7] In Texas, each call center employee must be certified by AIRS as a resource

[6] Alliance of Information and Referral Systems. Available: http://www.airs.org. Accessed: August 14, 2006.
[7] Alliance of Information and Referral Systems. Available: http://www.airs.org. Accessed: August 14, 2006.

specialist before being allowed to answer the phones. These AICs operate 24 hours a day, 7 days a week, 365 days a year. Specialists are multi-lingual and have access to a language line for individual clients.

When a client dials 2-1-1 Texas, they are presented with three options:

- **Option #1** is the local information and referral line. Clients are routed to their local area information center. Difficulties have been experienced by cell phone users and Voice over Internet Protocol (VoIP).
- **Option #2** is the Enrollment and Eligibility line for the Children's Health Insurance Program (CHIP), Medicaid, Temporary Assistance to Needy Families (TANF), and Food Stamps. Currently this option is only available for the pilot areas, Travis and Hays Counties. Calls are routed to the Texas Alliance call centers.
- **Option #3** is the reporting of waste, fraud and abuse line. These calls are routed to the State Office of the Inspector General.

Funding

Funding for 2-1-1 Texas comes from federal and state general revenue funds, as well as local community and private funds. Last biennium, 2-1-1 was appropriated $20 million in all funds ($9.5 million in 2006 and $11.4 million in 2007). Roughly half the monies came from the federal government. Allocation to the AICs is determined by a committee comprised of AIC presidents. Local funding for 2-1-1 is estimated at $8 million for the

biennium. Many area information centers rely on foundations and local non-profits to help fund their systems.

Cost-Benefit Analysis

In 2004, the United Way of America commissioned a study by the Ray Marshall Center for the Study of Human Resources and the Lyndon B. Johnson School of Public Affairs at the University of Texas to research the benefits, cost estimates, and net values created by a national three digit information and referral network for health and human services. Three of the four different models of 2-1-1 implementation were shown to have potential net value to society. Researchers estimated that the net value for the three models over a ten-year time period would be between $490 million and $530 million, depending on which model was used across the country.[8]

Disaster Preparedness

Hurricanes Katrina and Rita demonstrated the importance of having a coordinated disaster plan. 2-1-1 is the perfect system to help disseminate information relating to emergency preparedness, response and recovery.

2-1-1 Texas played a tremendous role in the recovery efforts for both Katrina and Rita by fielding over 59,000 calls after the hurricanes.[9] Callers were not only seeking help, but

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[8] Ray Marshall Center for Study on Human Resources at the LBJ School of Public Affairs, *National Benefit/Cost Analysis of Three-digit Accessed Telephone Information and Referral Service Final Report*: (December 2004).
[9] The United Way of the Gulf Coast, *In the Eye of the Storm,* Available: http://www.unitedwayhouston.org/pdfs/EyeoftheStorm.pdf. Accessed: 8/27/2006.

also offering to volunteer. The United Ways of Texas and their 2-1-1 outfits helped coordinate this relief effort. Expert staff from various 2-1-1 centers across the state continued to work at the FEMA Disaster Recovery Center months after the tragedies.[10] During Hurricanes Rita and Katrina, 2-1-1 calls focused on accessing evacuation information, shelter information, special health care needs, missing persons, and federal, state, and local assistance.

2-1-1 phone technology is equipped to handle an increased volume of calls if a certain region is hit by a disaster. During occasions where certain AICs are offline because of a disaster (example: Gulf Coast AICs hit by a hurricane), calls can be routed to other 2-1-1 call centers around the state.

One of the weaknesses identified during this time was the ongoing need to have the most accurate, up-to-the moment information. Relief efforts and strategies changed rapidly, and 2-1-1 operators were sometimes left unaware of these changes. The Rita evacuation in Houston also identified other needs that previously had not been addressed by any state's disaster plan. There was a strong need to have a better coordinated transportation system. Following the hurricanes, Governor Perry released executive orders RP 32 and RP 57 to order the development of the Division of Emergency Management in the Governor's office. The executive orders set guidelines for agencies to develop a coordinated state disaster plan with the help of both the Division of Emergency Management and Texas Homeland Security.[11]

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[10] *Ibid.*

[11] Available: http://www.governor.state.tx.us. Accessed: 8/27/2006.

RP 57 also orders the implementation of many of the recommendations by the Task Force on Evacuation Transportation and Logistics. One of the findings of the Task Force was the need to have a coordinated effort to evacuate those who are unable to evacuate themselves. Persons with special needs can currently call 2-1-1 and register for evacuation services in times of disaster.

2-1-1 Texas Emergency Management Protocols

In January 2005, the Health and Human Services Commission released the 2-1-1 Texas Emergency Management Protocols report. The purpose of the report is to detail and describe how the state's 2-1-1 system can and will be used to provide information, support, and other assistive services during an emergency event in Texas.[12] These protocols were developed with the cooperation of the Texas Office of Homeland Security and under the direction of the Office of the Governor's Division of Emergency Management. 2-1-1 will play a critical role in relaying information to the general public, providing instruction during emergency situations, and referring them to the appropriate resource.[13]

The Goals and Objectives of the 2-1-1 Emergency Management Protocols are to:

1) Enhance the capability and capacity of Texas to respond to and recover from emergency events,

[12] The Texas Health and Human Services Commission, *2-1-1 Texas Emergency Management Protocols Report*, January 31, 2005.
[13] *Ibid.*

2) Improve the capability of local governments to develop, prepare for and respond to emergency events by enhancing emergency planning, providing training, and conducting exercises to assess plans, procedures and training,

3) Support the collaborative efforts of local governments to develop regional, interlocking and mutually supporting plans and responses to emergency events,

4) Enhance the capabilities of state agencies and local governments in responding to all emergency events,

5) Facilitate and coordinate synchronized response efforts and information dissemination by local, state and federal organizations,

6) Promote planning, training and system response exercises for the local jurisdiction to improve their ability to respond to emergency events,

7) Protect life and property, and minimize suffering during emergency events, and

8) Facilitate rehabilitation and recovery.[14]

HHSC will require that all 2-1-1 Area Information Centers adhere to a set of disaster planning policies and standards. Each AIC must have a written business contingency plan and must also comply with AIRS standards on disaster preparedness. These centers will be required to continuously update disaster or emergency databases and must also participate in community planning with local and state governmental organizations. Staff is also required to be trained in emergency operations. In addition, AICs must also make

[14] *Ibid.*

sure that technology is enhanced to handle disaster scenarios where loss of business or facilities occurs.[15]

2-1-1 Texas is poised to serve an integral role in the state's disaster response system. The lessons learned from Hurricanes Katrina and Rita will help guide our state to develop a better response system. Preparation is well underway, but continued strong cooperation and coordination between local and state governments and community-based organizations is necessary for a successful system.

Integrated Eligibility System

House Bill 2292 78th (R) moved all eligibility determination functions of state entitlement programs to HHSC.[16] This bill also directed HHSC to develop call centers for eligibility and outsource these call centers, if cost-effective. After a thorough business case evaluation in 2004, HHSC determined that it would be cost-effective for these call centers to be outsourced. The goal of this new system was to create options for consumers and to modernize business processes to make cost-effective use of taxpayers' money.[17] This new system is designed to determine eligibility for the following programs:

- Children's Health Insurance Program (CHIP)
- Medicaid
- Food Stamps

[15] *Ibid.*
[16] Texas House of Representatives, House Bill 2292, 78th Regular Session.
[17] House Government Reform Committee, Testimony by Albert Hawkins Commissioner of the Health and Human Services Commission, (July 26, 2006).

- Temporary Assistance for Needy Families (TANF)
- Long-term care for the elderly and people with disabilities (financial eligibility)

Clients will ultimately be able to enroll in these programs by phone, fax, internet or in person at state eligibility offices. Those wishing to enroll by phone will be able to connect to services by dialing 2-1-1. When clients select Option # 2, they are routed to one of the Texas ACCESS Alliance's call centers to enroll for state services. At the time of this report, the 2-1-1 enrollment option is only available in the pilot areas of Travis and Hays Counties.

During the first pilot rollout of the new system, some clients were confused about who handled their cases. There were many instances where clients used Option # 1, which directed them to their Area Information Center. These centers only handle information and referrals and are not involved in the integrated eligibility determination. Call volumes to the Central Texas Region AIC increased dramatically during the first months of the rollout. Although AICs do not handle eligibility determination, they are able to assist clients in learning about additional state provided services and resources available to them in their community.

Concerns with Access

Today, many households no longer use land-line phone systems, prefering to use mobile phones or Voice over Internet Protocol. During the mid-1990s, mobile phone users had

early access issues when trying to dial 9-1-1. Technological advances have since led to higher access rates for this system. Similarly, during the early implementation of 2-1-1, wireless companies also had difficulty with connectivity. Now many of the larger wireless companies have access to 2-1-1. Some of the newer, smaller wireless phone companies, however, do not always have 2-1-1 connectivity. Many of these smaller companies cater to low income adults by offering low payment plans and little or no credit checks. The client base for these companies mirrors the client base that needs 2-1-1 access.

Recommendations

1. **Continue to fully fund state appropriations for the statewide information and referral network.**

   Rationale: The Legislative Budget Board and the Governor's office have asked each agency to cut 10 percent of their budget in the Legislative Appropriations Request. There is a continued need for fully funding the 2-1-1 system because of added call volumes and assistance needed during the continued rollout of the Integrated Eligibility System.

2. **Coordinate a 2-1-1 Public Awareness Campaign.**

   Rationale: During the rollout of integrated eligibility in the pilot areas, there was confusion about which option to use. HHSC should work with local media and community-based

organizations to educate clients about the different options within 2-1-1.

3. **Support efforts to increase dialog between states for disaster preparedness.**

Rationale: Natural disasters regularly involve more than one state. States need to have better communication and have coordinated disaster plans. This is particularly true in cases of hurricanes.

4. **Further integrate 2-1-1 into the State of Texas' Disaster Response and Planning.**

Rationale: Hurricanes Rita and Katrina highlighted the importance of using the 2-1-1 network to relay information. Integrating 2-1-1 in the state's disaster response plan will be key to disseminating information to the general public.

5. **Require wireless phone companies to provide 2-1-1 access.**

Rationale: Currently, only large wireless phone companies have 2-1-1 access. Many households use mobile phones as their primary phone lines. This will cause more problems when the integrated eligibility system is rolled out throughout the state. The smaller mobile phone companies cater to low income clientele who are the same people who need 2-1-1 services. Clients should have access to 2-1-1 regardless of what type of phone system is used.

6. **Require Voice over Internet Protocol service providers to inform consumers when they are unable to provide access to 2-1-1 services.**

Rationale: FCC is currently working on connectivity and access issues with 9-1-1. Larger service providers have been able to connect 2-1-1 customers to the right service area. However, smaller start-up companies still have access problems.

7. **Maximize opportunities to access federal funds.**

Rationale: The United States Congress is in the process of considering a national 2-1-1 act. Provisions include improving access to a nationwide 2-1-1 system. Drafted language includes the provision of $500 million to be made available to states over a five year period. However, states that do not already have a statewide 2-1-1 system could be given priority funding.

Charge 10: Implementation of HB 2292

Monitor the implementation of House Bill 2292, 78th Legislature, Regular Session, relating to health and human services. Focus on implementation of service coordination and consolidation efforts to assess the impact on service quality, while reducing costs.

Background

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

The biggest providers of social services in Texas are the health and human service agencies. They are charged with administering critical programs such as Medicaid, the Children's Health Insurance Program (CHIP), Food Stamps, and Temporary Assistance to Needy Families (TANF). Texas spent $19.5 billion in fiscal year 2002 funding these programs, a full 30 percent of total state spending. Finding greater efficiencies within the 12 agencies, which employ some 50,000 people,[1] was critical in order to minimize cuts in service levels. House Bill 2292 focused on finding these cost savings by "consolidating organizational structures and functions, eliminating duplicative administrative systems,

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

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

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

Beyond structural reform, HB 2292 sought to contain rising health care costs. Between FY 2000 and FY 2003, Medicaid expenditures rose 49 percent, from $10.087 billion in

[2] Texas Health and Human Services Commission, (n.d.) *Overview Of 2292: 78th Legislature, Regular Session*, 2003.
[3] Texas Health and Human Services Commission, *HHS in Transition, An Overview of the Texas Health and Human Services Reorganization: Requirements and Processes,* September 2003.
[4] Texas Health and Human Services Commission, *Integrated Eligibility Determination: Business Case Analysis* (February 2004).

FY 2000 to $15.012 billion in FY 2003.[5] Especially dramatic were increases in the cost of prescription drugs in the Medicaid program, rising 43 percent from FY 2000 to FY 2004.[6] HB 2292 contained a variety of cost containment measures, including implementation of enhanced fraud prevention measures and an integrated eligibility and enrollment system.

Agency Consolidation

HB 2292 consolidated the 12 existing health and human service agencies into four departments overseen by the Health and Human Services Commission. An executive commissioner, appointed by the Governor for a two-year term and approved by the Senate, oversees the operations of the Commission. Each department has its own commissioner, who is appointed by the executive commissioner under the approval of the Governor. Agency boards, which once were vested with rule and policy making authority, are replaced by councils, whose membership is determined by the Governor. Though responsible for advising agency commissioners on policy making, ultimate authority now rests with the executive commissioner, with input from the agency commissioners and councils. In order to eliminate duplication, administrative functions such as information technology, human resources, financial services and purchasing, were consolidated under HHSC, resulting in a cost savings of $95.6 million in FY 2003

[5] Texas Health and Human Services Commission, Written testimony submitted to the House Select Committee on State Health Expenditures (January 29, 2004).
[6] Texas Health and Human Services Commission. Written testimony submitted to the Texas House Appropriations Subcommittee on Health and Human Services (April 27, 2004), (Copy on file with the Texas House Appropriations Subcommittee on Health and Human Services).

and FY 2004.[7] Eligibility determination was also consolidated into HHSC with a net savings of $79.2 million FY 2003 and FY 2004).

Summary of Agency Consolidation

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

Consolidation Implementation

HHSC began its consolidation immediately after the passage of HB 2292. The implementation process had four phases: planning, integrating, optimizing, and transforming. The *planning phase* included a functional review "that focused on documenting current agency business functions and analyzing requirements for the future

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

consolidation," formation of a Transformation Program Management Office to guide the implementation process, and creation of a Transition Plan. The Transition Plan was submitted to the Governor and Legislative Budget Board in November 2003.

On December 29, 2003, HHSC announced its commissioner appointments for the four health and human service departments. Planning in for the agency councils began in January 2004. Also in January 2004, consolidation of many of the administrative functions was completed. Finally, the creation of the Office of Inspector General (OIG) occurred in January 2004. "The Office of Inspector General assumed all the duties of HHSC's Office of Investigation and Enforcement and also all fraud and abuse functions of other health and human services (HHS) agencies."[8]

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

The first agency consolidation, that of the Department of Family and Protective Services (DFPS), occurred on February 2, 2004. The Department of Assistive and Rehabilitative Services (DARS) soon followed. Departments of State Health Services (DSHS) and Aging and Disability Services (DADS) consolidated operations in September, 2004.[9]

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[8] Texas Health and Human Services Commission, *Overview of the Office of Inspector General*. Online. Available: http://www.hhsc.state.tx.us/OIE/OIE_info.html. Accessed: June 24, 2004.
[9] Texas Health and Human Services Commission. *HHS Transformation, Frequently Asked Questions*. Online. Available: http://www.hhsc.state.tx.us/Consolidation/Consl_FAQ.html. Accessed: June 24, 2004.

The *integrating phase* occurred to help focused on maintaining service delivery while agency consolidation continued. The *optimization phase* "will be that phase…where the longer-range vision of HB 2292 and HHSC began to be realized…and leaders were expected to begin rationalizing and streamlining the business processes for which they are responsible."[10] And, the *transforming phase* consisted of agency "include continued implementation of changes in health and human services department management activities, continuation of risk assessments, and conducting a transformation review of the changes to the delivery of health and human services"[11] in an effort to become a continuously improving agency.

Through this entire process, the Transition Legislative Oversight Committee (TLOC) exercised oversight authority. Created by HB 2292, the committee was tasked with "[facilitating] the transfer of powers, duties, functions, programs, and activities between the state's health and human services agencies and the Health and Human Services Commission…with a minimal negative effect on the delivery of those services in this state."[12] The committee was composed of four legislative members (two from the House and two from the Senate), three public members, and HHSC's executive commissioner. Between September 2003 and June 2004, the committee held six hearings and HHSC's commissioners presented updates on their progress and committee members were able to address areas of concern.

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[10] Texas Health and Human Services Commission, *HB 2292 Transition Plan, November 3, 2003*. (November 3, 2003). Online. Available: http://www.hhsc.state.tx.us/Consolidation/HB_2292/110303_HB2292TP1.html. Accessed: June 16, 2004.
[11] Texas Health and Human Services Commission, *HB 2292 Transition Plan, November 3, 2003* (November 3, 2003). Online. Available: http://www.hhsc.state.tx.us/Consolidation/HB_2292/110303_HB2292TP1.html. Accessed: June 16, 2004.
[12] Texas House Bill 2292, 78th Legislature, regular session (2003), pp. 71-74.

Early Results

By all accounts, the efficacy of the consolidation of health and human services is mixed. While the basics of consolidating administrative service seem to be successful, more ground-breaking aspects of the plan appear to have experienced, at least, temporary difficulties.

Successes

According to the HHSC's Consolidated Budget for the 2008 - 09 Biennium, $1.76 billion in general revenue has been saved since 2002 as a result of HB 2292.[13] In each case, savings efforts have been focused on obtaining administrative efficiencies within the Commission's structure or ensuring that funds for services were spent on those truly eligible for them. The chart below provides an outline of savings initiatives and the dollar and FTE reductions associated with them. Many of these savings were implemented as reductions in funding within the General Appropriations Act, thus making them more difficult to accurately determine.

[13] Texas Health and Human Services Commission, *Consolidated Budget Fiscal Years 2008 and 2009*, (October 13, 2006), p. 15.

Major HHS Agencies Savings Initiatives since FY 2002

FY 2002 - 2003	GR	FTEs
78th Legislature, HB 7 -- FY 2003 Reduction Plan	$133.9	39
77th Legislature, Business Process Study -- Rider Reduction	$10.0	19
77th Legislature, Medicaid Cost Containment -- Rider Reduction	$205.0	--
Subtotal	**$348.9**	**58**

FY 2004 - 2005	GR	FTEs
78th Legislature -- Initial GR Reduction	$320.4	664
78th Legislature -- Program Savings Included in General Appropriations Act		
Maintain 6 months continuous eligibility in Medicaid	*$282.4*	--
CHIP Policy Changes	*$144.5*	--
Preferred Drug List	*$140.0*	--
Client Transportation Transfer	*$104.3*	--
Medicaid Benefit Changes	*$43.1*	--
TANF Pay for Performance	*$29.1*	--
Other Initiatives	*$89.0*	--
Subtotal -- Program Savings	*$832.4*	--
78th Legislature -- HB 2292 Reductions		
Consolidation of Agencies / Administrative Reductions	*$50.4*	*671*
Programmatic Savings Reduced in Agency Budgets	*$27.6*	*1,115*
Subtotal -- HB 2292 Reductions	*$78.0*	*1,786*
78th Legislature -- Additional Savings Identified by HHS Agencies	$83.8	--
Subtotal	**$1,314.6**	**2,450**

FY 2006 - 2007	GR	FTEs
79th Legislature -- Rider Reduction for Services to Medicaid Aged / Blind / Disabled populations	$73.0	--
79th Legislature -- Rider Reduction for Multi-State Drug Purchasing Pool	$17.6	--
79th Legislature -- DSHS Reductions	$6.7	52
79th Legislature -- 2% FTE Reductions	--	720
Subtotal	**$97.3**	**772**

Total GR Savings : FY 2002 - 2007	$1,760.8	3,280

Source: Texas Health and Human Services Commission, Consolidated Budget Fiscal Years 2008 and 2009, (October 13, 2006), p. 16.

In addition to monetary savings, administrative successes include such items as consolidated ombudsman services for clients experiencing difficulties within the system, facilities optimization, implementation of a consolidated procurement and contract

system, merged legal services, and creation of a consolidated civil rights office.[14] Centralized rate requests have also assisted in the provision of a suitable workforce for social services clients.

Challenges

In September 2005, the Texas State Auditor's Office issued a report critical of the Commission's outsourcing of its administrative support functions. Specifically, the report found that the agency had not used accurate cost data in its decision to outsource human resources and payroll functions. In fact, it could not be determined if any cost savings had resulted from the outsourcing. The Auditor's Office also found a lack of performance measures in its contracts and significant errors on the part of the contractor.[15] The agency indicates that these issues have been resolved and that the underlying causes have been corrected.

In an effort to reduce costs, HB 2292 directed HHSC to study whether the use of call centers for enrollment and eligibility determination would be cost effective and to decide if these call centers should be privatized. For a detailed description of the new process see: *The Senate Committee on Health and Human Services Report to the 79th Legislature*, Interim Charge # 2 regarding HB 2292 implementation. Competitive procurement through a request for proposal determined that outsourcing was more cost-effective than state-operated call centers. The cost of state-operated call centers was

[14] Texas Health and Human Services Commission, *Consolidated Budget Fiscal Years 2008 and 2009*, (October 13, 2006), p. 17.
[15] Texas State Auditor, *An Audit Report on the Health and Human Services Commission's Consolidation of Administrative Support Functions*, (September 2005).

projected to be 15 percent, or $436.4 million, less than baseline costs over a five-year period. The cost of outsourced call centers was projected to be 22 percent, or $646.1 million, less than baseline costs over a five-year period.[16]

HHSC contracted with the Texas ACCESS Alliance (TAA) for multiple responsibilities. TAA has assumed duties from previous vendors including CHIP eligibility**,** Medicaid and CHIP managed care enrollment broker services, and maintenance of the Texas Integrated Eligibility Redesign System – TIERS. TAA was also contracted for and is responsible for the integrated eligibility services for Medicaid, Food Stamps, and TANF. Currently, this system is only operating in the pilot areas of Travis and Hays Counties, which includes four out of over 300 eligibility offices.

Implementation Timeline for Texas Access Alliance:

Enrollment Broker:		
	Assumed responsibilities from previous vendors	November 1, 2005
TIERS Maintenance:		
	Assumed responsibilities from previous vendor	November 1, 2005
CHIP:		
	Assumed responsibilities from previous vendor	December 1, 2005
Children's Medicaid *(excluding recertification)***:**		
	Assumed responsibilities from previous vendor	January 1, 2006
New Eligibility System Pilot:		
	Two counties : Travis and Hays17	January 2006

Under the integrated eligibility and enrollment model, clients will have five access channels to apply for Temporary Assistance to Needy Families, Food Stamps, Medicaid and CHIP, and Long-term Care Financial Eligibility:

[16] Texas Health and Human Services Commission, Written testimony given to the House Government Reform Committee, (August 8, 2006).
[17] Texas Health and Human Services Commission, Written testimony given to the House Government Reform Committee, (August 8, 2006).

1) **In-Person**: 167 full-service state eligibility offices, open between 8:00 a.m. and 5:00 p.m., Monday through Friday; 44 satellite offices open by appointment; mobile units and eligibility workers at 300 hospitals/medical facilities.

2) **By Phone**: 8:00 a.m. to 8:00 p.m., Monday through Friday, in English/Spanish/Vietnamese plus a language line for other languages; Relay Texas/TDD for hearing impaired.

3) **Internet**: Screen for potential eligibility, apply for services, and check the status of applications.

4) **Fax**

5) **Mail**[18]

This newly modernized eligibility system will ultimately benefit the clients by offering multiple entry options.

Initially, clients complained about long call wait times, missing information that was submitted by clients, inadequately trained TAA call center staff, processing delays and computer system glitches. In April 2006, the Commission, in an effort to correct the above issues, delayed further rollout of the IEE systems until performance from TAA improves. HHSC has taken steps to improve monitoring and quality assurance and to strengthen the training curriculum for the TAA call center representatives. HHSC has also revised the renewal of the CHIP and Medicaid timeline and extended the time period

[18] Texas Health and Human Services Commission, *Written testimony given to the Senate Committee on Health and Human Services on HB 2292 Implementation*, (March 2006).

for payment of enrollment fees for CHIP. State staff is positioned with the call center representatives to ensure that clients receive accurate information. Additionally, HHSC retained a number of state workers to help with the backlogged cases. Under contract provisions, HHSC has the ability to seek remedies from TAA and is currently exploring that option.

Recommendations

1. **HHSC should produce reports to the Legislature outlining contracting achievements and problems based on performance measures in their contracts.**

   Rationale: This will help Legislators be fully informed on large contracts to help them make informed decisions during the appropriations and legislative processes.

2. **Provide input cards in program registration or renewal materials, as well as on the web, to solicit input from the public in evaluating program performance.**

   Rationale: It is important for the health and human services agencies to be aware of consumers' concerns. This step will better assist to develop policies that directly affect these consumers.

3. **Require the HHSC to produce a "cost avoidance" report detailing programs in which savings directly attributable to HB 2292 are identified.**

Rationale: During Senate Finance Committee hearings on this issue, members were concerned that there were no definitive numbers on cost avoidance. This report would provide information for such questions.

Appendices

Appendix A: AIC Map

25 Area Information Centers
Regional Boundary Map

2-1-1 Sites

Panhandle Region

South Plains Region

West Central Texas Region

Concho Valley Region

Permian Basin Region

Rio Grande Region

North Texas Region

North Central Texas Fort Worth Region

North Central Texas Dallas Region

Texoma Region

North East Texas Region

East Texas Region

Heart of Texas Region

Central Texas Region

Deep East Texas Region

Bryan/ College Station

South Central Texas Region

Gulf Coast Region

Southeast Texas Region

Golden Crescent Region

Coastal Bend Region

Alamo Region

Middle Rio Grande Region

South Texas Region

Tip of Texas Region

Texas Information and Referral Network
909 W. 45th Street, Bldg. 2 / MC2077
Austin, Texas 78751

(512) 206-4787
http://www.hhs.state.tx.us/tirn/tirnhome.shtml

Appendix B: Responses from Committee Members

STATE OF TEXAS
THE SENATE OF TEXAS

E JANEK
EMBER

November 30, 2006

The Honorable Jane Nelson
Chair
Senate Committee on Health & Human Services
Capitol, Room 1E.3

Dear Chairman Nelson:

Thank you for your leadership during the 79th Interim as chair of the Senate Committee on Health and Human Services. I am signing the Report to the Legislature as an endorsement of this committee's hard work and the many strong recommendations upon which we agree. I would like to outline one of my concerns.

> *Charge 6, Recommendation 5: Require fitness assessments of all students, kindergarten through grade 12, to determine the impact of current efforts on academic achievement, absenteeism, obesity, discipline problems and school lunch programs.*

I believe maintaining the health and physical fitness of our children is an admirable goal. I do not believe mandatory school-based fitness assessments for every child in kindergarten through twelfth grade is the best way to maintain our childrens' health. As a believer in personal responsibility and free markets, I do not believe schools should take over one more function that should be handled by individual families.

Please include this letter as a record of my comments on the report. Again, I appreciate the dedication and leadership you have shown as Chairman of this subcommittee. I look forward to working with you in the 80th Legislature.

Sincerely,

Kyle Janek

KJ/ch

SENATE DISTRICT 17
POST OFFICE BOX 12068 AUSTIN, TEXAS 78711 • (512) 463-0117 • KYLE.JANEK@SENATE.STATE.TX.US

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Vice Chair, Finance
Chair, Subcommittee on Higher Education
Chair, Subcommittee on Capital Funding for Higher Education
Legislative Budget Board

Judith Zaffirini
State Senator, District 21
President Pro Tempore, 1997

Committees
Education
Health and Human Services
International Relations and Trade

December 1, 2006

Senator Jane Nelson, Chair
Senate Health and Human Services Committee
Texas Legislature
Austin, Texas 78711

Dear Chair Nelson:

Thank you for your leadership as Chair of the Senate Health and Human Services Committee. It is my privilege to serve with you, and I appreciate the opportunity to share my perspective regarding the Interim Report to the 80th Legislature. Although I signed the report because it includes many fine recommendations that could improve the quality of health and human services for many Texans, I submit this letter to record some of my abiding concerns.

As a lifelong advocate for persons with disabilities, I am disappointed by the report's lack of attention to their issues. Charge Two recommendations do not address Medicaid reform issues related to improving long term services and supports, to end waiting lists, or to reduce fragmentation and waste in the waiver system. What's more, while there is a recommendation to increase reimbursement rates for physicians, there is no mention of increasing wages for community direct care workers. These hard-working medical professionals are critical to the quality of community long term supports and services. They do difficult work, have low wages, and are especially deserving of support.

Thank you for your dedication to the many important issues included in the report. Count on my continued leadership to help ensure that every Texan has access to quality health and human services. I look forward to continuing working with you and other members of the committee during the forthcoming legislative session. May God bless you.

Very truly yours,

Judith Zaffirini

Judith Zaffirini

JZ/jr

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