TEXAS SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

INTERIM REPORT
TO THE
89TH LEGISLATURE

December 2024

THE SENATE OF TEXAS
COMMITTEE ON HEALTH AND HUMAN SERVICES

SAM HOUSTON BLDG.
ROOM 420
P.O. BOX 12068
AUSTIN, TEXAS 78711
(512) 463-0360
FAX: (512) 463-9889
DIAL 711 FOR RELAY CALLS

E-MAIL:
Lois.Kolkhorst@senate.texas.gov

December 10, 2024

The Honorable Dan Patrick
Lieutenant Governor of Texas
P.O. Box 12068
Austin, TX 78711

Dear Governor Patrick,

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

Respectfully submitted,

Senator Lois Kolkhorst, Chair

Senator Charles Perry, Vice-Chair

Senator César Blanco

Senator Bob Hall

Senator Kelly Hancock

Senator Bryan Hughes

Senator Morgan LaMantia

Senator Borris Miles

Senator Kevin Sparks

Table of Contents

INTERIM CHARGES

I. Children's Mental Health: Review care and services currently available to the growing population of Texas children with high acuity mental and behavioral health needs. Make recommendations to improve access to care and services for these children that will support family preservation and prevent them from entering the child welfare system.

II. Access to Health Care: Evaluate current access to primary and mental health care. Examine whether regulatory and licensing flexibilities could improve access to care, particularly in medically underserved areas of Texas. Make recommendations, if any, to improve access to care while maintaining patient safety.

III. Health Insurance: Examine the Texas health insurance market and alternatives to employer-based insurance. Identify barriers Texans face when navigating a complex health insurance market. Make recommendations that help individuals obtain health care coverage.

IV. Cancer Prevention: Identify and recommend ways to address the growing impact of cancer on Texans by evaluating state investments in cancer prevention and screenings including, but not limited to, "CT," "MRI," and "PET" scans. Study and make recommendations on funding adequacy for prevention efforts at the Cancer Prevention and Research Institute of Texas (CPRIT).

V. Monitoring: Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services passed by the 88th Legislature, as well as relevant agencies and programs under the committee's jurisdiction. Specifically, make recommendations for any legislation needed to improve, enhance, or complete implementation of the following:

- Senate Bill 7, Third Called Special Session, relating to prohibiting a private employer from adopting or enforcing certain COVID-19 vaccine mandates; authorizing an administrative penalty;

- Senate Bill 24, relating to the powers and duties of the Health and Human Services Commission and the transfer to the commission of certain powers and duties from the Department of Family and Protective Services;

- Senate Bill 25, relating to support for nursing-related postsecondary education, including scholarships to nursing students, loan repayment assistance to nurses and nursing faculty, and grants to nursing education programs;

- Senate Bill 26, relating to local mental health authority and local behavioral health authority audits and mental and behavioral health reporting, services, and programs; and

- Senate Bill 1849, relating to an interagency reportable conduct search engine, standards for a person's removal from the employee misconduct registry and eligibility for certification as certain Texas Juvenile Justice Department officers and employees, and the use of certain information by certain state agencies to conduct background checks.

V. Monitoring: Medicaid Fraud: Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services passed by the 88th Legislature, as well as relevant agencies and programs under the committee's jurisdiction. Specifically, make recommendations for any legislation needed to improve, enhance, or complete implementation of the following:

- Initiatives to reduce Medicaid fraud, waste, and abuse, as well as other cost containment strategies; and
- Medicaid managed care oversight and accountability

VI. Protecting Vulnerable Texans in Emergencies: Examine commercial residential settings for the elderly and individuals with intellectual disabilities, including assisted living facilities, boarding homes, group homes, and independent living communities. Identify emergency preparedness and response protocols required during severe weather for these populations. Make recommendations, if necessary, for the establishment and enforcement of emergency protocols to ensure vulnerable populations are protected.

INTERIM CHARGE I: CHILDREN'S MENTAL HEALTH

Children's Mental Health: *Review care and services currently available to the growing population of Texas children with high acuity mental and behavioral health needs. Make recommendations to improve access to care and services for these children that will support family preservation and prevent them from entering the child welfare system.*

Introduction

The Texas Senate Committee on Health and Human Services conducted an interim hearing on September 18, 2024, to better understand the needs of children in Texas diagnosed with high acuity mental illness. Many of these children are in systems managed by the state, including the Department of Family and Protective Services (DFPS) and the Texas Juvenile Justice Department (TJJD).

Experts were invited to testify and to educate the members of the committee on the populations of children that are suffering from higher acuity conditions, what resources are available to those children, and where gaps exist in the current treatment options for those populations that are in conservatorship of the state or are in the juvenile justice system.

While the committee's interim charge in this area focused on the highest acuity juvenile populations, members and witnesses also spoke to the need for a broader discussion of what is driving the increase in mental health conditions among adolescents and what is needed to address those issues.

Background

Across the United States, the prevalence of mental health conditions in children has been rising. Nearly three out of five high-school girls in the U.S. who were surveyed reported feelings of persistent sadness or hopelessness in 2021, a roughly 60 percent increase over the past decade, the Centers for Disease Control and Prevention found.[1] Data are similar in Texas.

The committee invited two panels of witnesses to provide insights and data related to higher acuity mental illness in children. The Department of Family and Protective Services (DFPS), the Texas Juvenile Justice Department (TJJD), and the Health and Human Services Commission (HHSC) provided a summary of the existing services for mental health treatment as well as the current challenges with children involved in Child Protective Services and Juvenile Justice.

[1] Sarah Toy, "Teen Girls Experiencing Record Levels of Sadness and Suicide Risk, CDC Says," *The Wall Street Journal*, February 13, 2023.
https://www.wsj.com/articles/teen-girls-experiencing-record-levels-of-sadness-and-suicide-risk-cdc-says-b30b7e8e?mod=article_inline&mod=article_inline

Summary of the Testimony

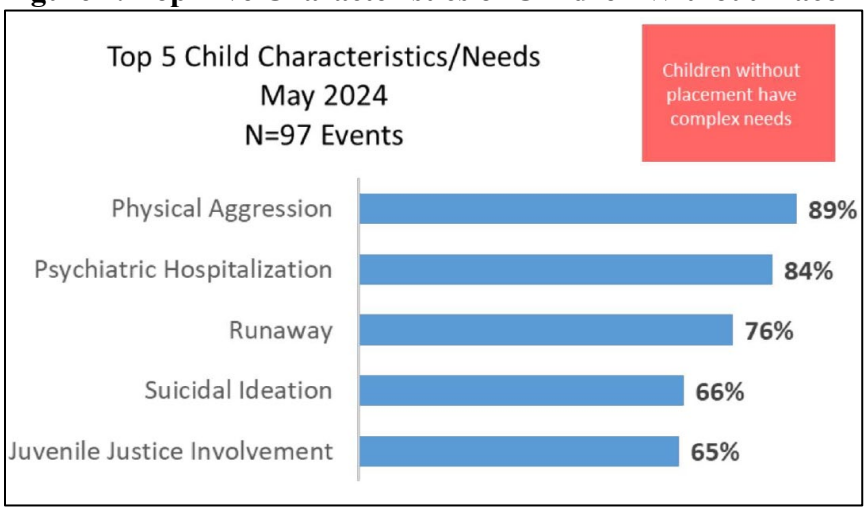
The number of children suffering with major acuity levels with involvement in the Texas child welfare and juvenile justice systems is rising. The Department of Family and Protective Services and the Texas Juvenile Justice Department provided statistics to the committee during invited testimony on the rates of children entering these systems with behavioral issues.

High Acuity Children in Foster Care and Juvenile Justice

For DFPS, the most acute conditions can be found in the population of children known as Children Without Placement (CWOP). CWOP refers to youth for whom DFPS cannot find a licensed or suitable placement despite exhausting all efforts.[2]

Figure 1 highlights the top characteristics of CWOP children in conservatorship. In FY 2023, 27 percent of children who entered CWOP came from Jail/Juvenile Detention, compared to nine percent in FY 2021. Similarly, this trend holds for children with substance and/or alcohol use or a diagnosis of Intellectual Development Disability (IDD): 46 percent in FY 2023 compared to 29 percent in FY 2021.

Figure 1. Top Five Characteristics of Children Without Placement in DFPS Custody



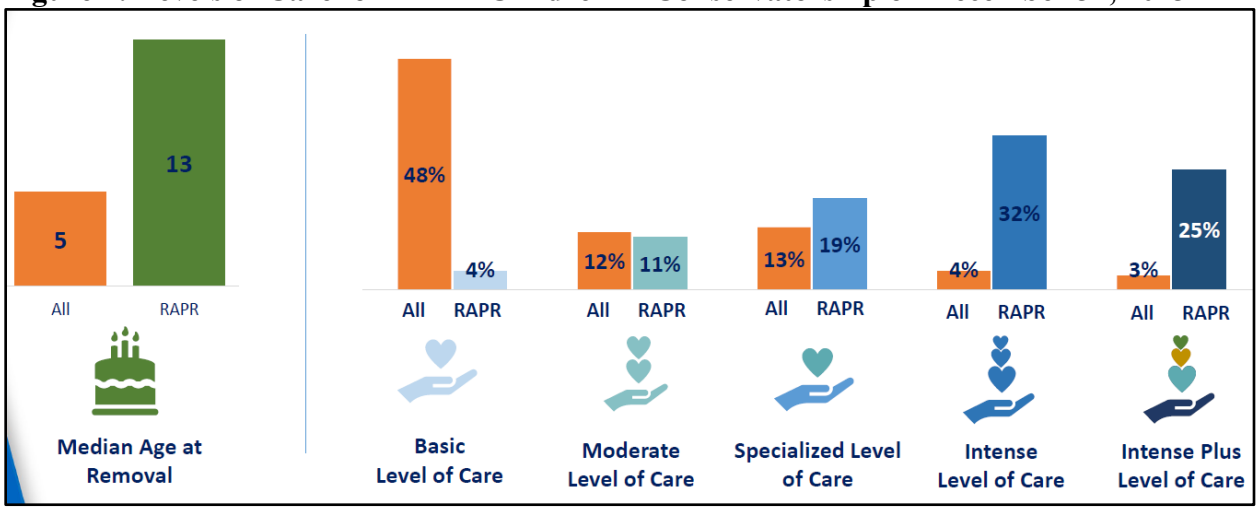
***Source**: DFPS Data*

DFPS Commissioner Stephanie Muth explained that a major portion of the higher acuity CWOP children entered the system from a relinquishment by the youth's parents, as opposed to a report of abuse or neglect. Relinquishments—known as Refusal to Accept Parental Responsibility (RAPR)—can arise for various reasons, including a family's lack of access to affordable mental health or medical services, or a parent's inability to meet their child's needs in the home. Historically, parents of children with diagnosed emotional disturbances sought to relinquish

[2] Stephanie Muth, Department of Family and Protective Services, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.

custody to DFPS to secure mental illness treatment, and a 2015 law in Texas exempted these actions from being considered "child neglect."[3]

Figure 2: Levels of Care for RAPR Children in Conservatorship on December 31, 2023



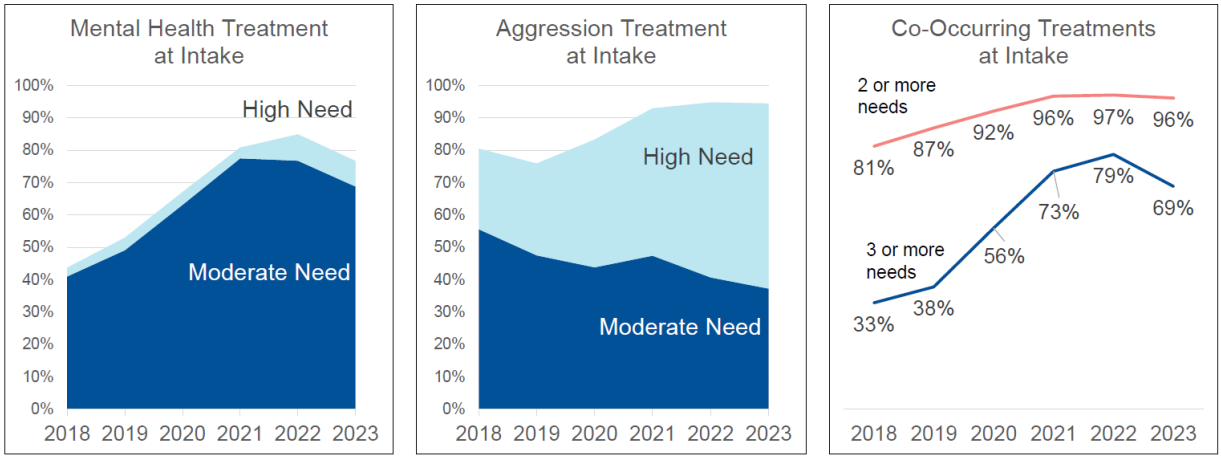
Source: *DFPS "CVS Big Data." *Note: Child Specific Contracts are included in "Intense Plus Level of Care." Authorized Service Level of Care excludes children in SSCC's.*

The trends suggest that many families are grappling with how to address the needs of their children with higher behavioral and mental health needs or even with intellectual disabilities and have reached their limit. The profile of one foster child called "John," 17-year-old who lacked a foster placement for 422 nights, exemplifies this phenomenon. This child had a history of severe aggression, oppositional defiance, and extensive trauma, which led to his relinquishment to DFPS custody. He experienced 41 different placements, including stays in hotels supervised by DFPS staff, at an average of $1,700 per night. Further, it required 200 to 500 hours of staff time at DFPS.[4]

Similar patterns are observed in the population of children entering juvenile detention. Mental health and chronic pain issues are a significant feature in the juvenile populations today, which complicates the agency's ability to provide appropriate care.[5] Consequently, TJJD has established quasi-inpatient psychiatric units and, on average, is treating about 300 general population youth, with an additional 750 requiring high-intensity services.

[3] Texas Family Code § 261.001(4)(B)(i)
[4] Stephanie Muth, Department of Family and Protective Services, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.
[5] Shandra Carter, Texas Department of Juvenile Justice, *Testimony Before the Texas Senate Committee on Health and Human Services*, September 18, 2024.

Figure 3: Trends in TJJD Youth Mental Health and Aggression Attributes at Intake



Source: *TJJD Presentation to Texas Senate Health and Human Services Committee*

Additionally, both DFPS and TJJD testified that an increasing percentage of the populations they serve transition between both systems.

Figure 4: Crossover between TJJD and DFPS Involved Youth

Offense Type	TJJD Youth, FY22-23	TJJD Youth Ever in Foster Care, FY22-23	Percent Ever in Foster Care
Violent	1,554	263	16.9 percent
Property	312	43	13.8 percent
Drug	76	5	6.6 percent
Other	137	18	13.1 percent
Total	2,079	329	15.8 percent

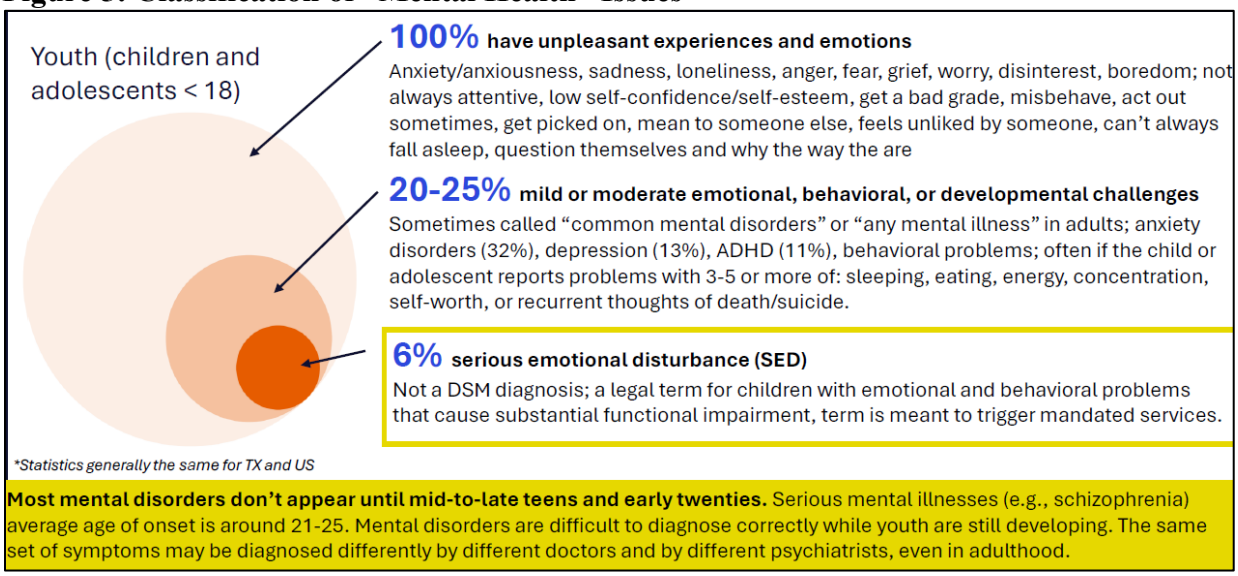
Source*: TJJD Presentation to Texas Senate Health and Human Services Committee*

Identifying the High-Needs Child Population in Mental and Behavioral Health Services

Invited witnesses identified the specific populations in Texas children who need specialized services for acute mental and behavioral health care. They also outlined the current landscape of children's mental health care in Texas and various services and systems enacted to focus efforts on the needs of children with higher acuity mental and behavioral health conditions.

Carolyn Gorman, a data analyst with the Manhattan Institute, explained that about 20 percent of youth may face mild to moderate emotional, behavioral, or developmental challenges that meet diagnostic criteria, but only about six percent of youth experience *serious* emotional disturbances, which can cause significant impairment in their daily lives. Figure 5 illustrates the delineation between the broader child population that may experience "mental health issues" versus the smaller number of children who suffer from serious disturbances and require clinical assistance.

Figure 5: Classification of "Mental Health" Issues



Source: *Manhattan Institute*

Andy Keller, president and CEO of the Meadows Mental Health Policy Institute, explained how Texas has begun "laying the groundwork" for a system that can begin to address mental and behavioral health issues at an earlier point in a child's life while developing an integrated system that can address a conium of mental health needs from less acute issues to more intensive care.[6] State investment in the Texas Child Mental Health Care Consortium (TCMHCC), created under Senate Bill 11 (86R), is providing a platform for these services.

Currently, in Texas, there are about 5.2 million school-aged children, and approximately 75 percent of mental health needs emerge before age 24, meaning approximately 2 million youth in Texas currently have mental health needs. About 1.3 million of these youth can be effectively treated within integrated primary care.[7] The early detection of mental health issues in children through investments in the TCMHCC, which is developing screening and better detection in both schools and through primary acute medical providers, is helping to prevent greater crisis through primary care and allowing those with the highest acuity needs to access more acute services.

Texas Systems for Addressing High Acuity Mental and Behavioral Health Youth

Texas has made significant investments in mental and behavioral health over the last several legislative sessions. The total state investment in mental health services across all government articles and programs was $11.6 billion,[8] reflecting an increase of more than 70 percent over the last decade.

[6] Andy Keller, Meadows Mental Health Policy Institute, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.
[7] *Ibid.*
[8] Texas Legislative Budget Board, *Testimony before the Texas Senate Finance Committee*, September 5, 2024.

Figure 6: Behavioral Health Funding by Legislature (All Funds)

	84th Legislature	85th Legislature	86th Legislature	87th Legislature	88th Legislature
Art. IX, Section 10.04, Funding by Article	**2016-17 GAA Appropriations**	**2018-19 GAA Appropriations**	**2020-21 GAA Appropriations**	**2022-23 GAA Appropriations**	**2024-25 GAA Appropriations**
Article I	$ 14.6	$ 21.8	$ 164.8	$ 106.2	$ 152.0
Article II	$ 2,887.9	$ 3,293.6	$ 3,348.6	$ 3,355.2	$ 4,553.1
Article III	$ 20.0	$ 24.0	$ 133.5	$ 153.1	$ 341.5
Article IV	$ -	$ 0.6	$ 8.6	$ 8.6	$ 8.8
Article V	$ 666.0	$ 694.7	$ 706.9	$ 716.9	$ 768.3
Article VI	$ -	$ -	$ -	$ -	$ 1.0
Article VIII	$ 3.6	$ 4.0	$ 4.3	$ 4.3	$ 17.3
Cross-Article Total, Excluding Medicaid & CHIP	**$ 3,592.2**	**$ 4,038.7**	**$ 4,366.7**	**$ 4,344.3**	**$ 5,842.1**
Supplemental Appropriation Funding by Agency	**HB 2, 84(R)**	**HB 2, 85(R)**	**SB 500, 86(R)**	**HB 2, 87(R) SB 8, 87(3)**	**SB 30, 88(R)**
Texas Facilities Commission	$ -	$ -	$ -	$ 40.0	$ 86.7
Comptroller of Public Accounts, Fiscal Programs	$ -	$ -	$ -	$ -	$ 26.8
Health and Human Services Commission	$ -	$ 15.1	$ 475.1	$ 586.1	$ 2,125.2
Texas Higher Education Coordinating Board	$ -	$ -	$ -	$ 113.1	$ -
University of Texas - Health Science Center at Houston	$ -	$ -	$ -	$ -	$ 8.0
University of Texas - Health Science Center at Tyler	$ -	$ -	$ -	$ -	$ 7.0
Supplemental Appropriations Total	**$ -**	**$ 15.1**	**$ 475.1**	**$ 739.2**	**$ 2,253.7**
Medicaid and CHIP Funding by Program	**2016-17 GAA Appropriations**	**2018-19 GAA Appropriations**	**2020-21 GAA Appropriations**	**2022-23 GAA Appropriations**	**2024-25 GAA Appropriations**
Estimate Behavioral Health-related Medicaid	$ 3,079.1	$ 3,517.1	$ 3,314.9	$ 3,677.1	$ 3,481.4
Estimate Behavioral Health-related CHIP	$ 42.0	$ 48.7	$ 101.5	$ 98.9	$ 86.3
Estimated Medicaid & CHIP Total	**$ 3,121.1**	**$ 3,565.8**	**$ 3,416.4**	**$ 3,776.0**	**$ 3,567.7**
Total Funding by Legislature	**$ 6,713.3**	**$ 7,619.6**	**$ 8,258.2**	**$ 8,859.5**	**$ 11,663.5**

***Source**: LBB Data:https://www.lbb.texas.gov/Documents/Publications/Presentation/Appropriations_to_Infrastructure_Funds.pdf*

Commensurate with these investments, Texas has implemented services and systems that aim to identify and address high-acuity children in need of mental and behavioral health services or children in high-risk situations.[9]

Dr. David Lakey, vice chancellor for health affairs at The University of Texas System and professor of medicine at The University of Texas at Tyler Health Science Center, outlined the investments in services to children through TCMHCC, which is designed to address gaps in mental health care for children and adolescents in Texas through the delivery of school-based direct treatment and care and the development of a "public health" model for screening and treating mental health via the acute medical system. It also aims to address the shortage of psychiatrists in Texas. [10] It features several distinct programs, including:[11]

- **Child Psychiatry Access Network** (CPAN): A network of child psychiatry access centers based at the health-related-institutions (HRIs) that will provide child and adolescent behavioral health consultation services and training opportunities for pediatricians and primary care providers (PCP).

[9] David Lakey, University of Texas System, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.
[10] *Ibid.*
[11] University of Texas System, "Texas Child Mental Health Care Consortium," *Accessed November 21, 2024.* https://tcmhcc.utsystem.edu/

- **Texas Child Health Access Through Telemedicine** (TCHATT): Telemedicine or telehealth programs using HRIs to support local school districts (ISDs) to assist schools in identifying and assessing the behavioral health needs of children and adolescents and providing access to mental health services.

- **Community Psychiatry Workforce Expansion** (CPWE): Full-time academic psychiatrists are funded to serve as academic medical directors at facilities operated by community mental health providers, and new psychiatric resident rotation positions are established at these facilities.

- **Child and Adolescent Psychiatry Fellowships** (CAP Fellowships): This program expands both the number of child and adolescent psychiatry fellowship positions in Texas and the number of these training programs at Texas HRIs.

- **Research:** Development of a plan to promote and coordinate mental health research across state university systems in accordance with the statewide behavioral health strategic plan developed by the Texas Health and Human Services Commission (HHSC).

The Texas Child Health Access Through Telemedicine (TCHATT) program, a school-based telehealth program that connects pediatricians with mental health professionals, allows for rapid consultations (averaging under five minutes) to support children in need, especially those in foster care. Over 13,000 providers are involved, with significant growth in consultations.

TCHATT serves approximately four million students in Texas, but there is a drop-off in referrals and enrollments, often due to existing care or parental refusal. The main reasons for referrals include anxiety, depression, and behavioral issues. Over the last three years, TCHATT has provided services to more than 44,000 kids, totaling nearly 200,000 sessions. For the highest-risk youth, specific interventions through the community mental health system, such as crisis outreach teams and multisystemic therapy, can serve as effective interventions.[12]

Trina Ita, Deputy Executive Commissioner for Behavioral Health at HHSC, summarized the variety of mental and behavioral health services offered to Texas children through HHSC's Community Mental Health Services. Children who are not eligible for Medicaid ages three to 17 may qualify for community-delivered services if they:

- Have a serious emotional disturbance or SED; and
- Have a serious functional impairment; or
- Are at risk of leaving their home environment due to psychiatric symptoms; or
- Are in special education because of emotional disturbance.

[12] David Lakey, M.D., University of Texas System, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.

These services are provided in concert with local mental and behavioral health authorities (LMHAs) and can be prescribed and delivered at home or via outpatient office settings and the programs under these contracts. Services include:

- Adult and Children's mental health counseling and services.
- Crisis services, which include community-based in-patient psychiatric services through LMHAs and include dedicated capacity for youth and for the use of the children in DFPS custody.
- Youth crisis outreach services and mobile crisis outreach: Community-based mental health follow-up and support after a crisis.
- Youth Empowerment Services (YES) waivers.
- Crisis therapy services (coordinated specialty care (CSC)/multi-systemic therapy (MST)): MST is offered through 22 teams across the state and provides families at risk for mental health crisis with a child or adolescent with intensive case management.
- Residential treatment center project: Approximate capacity of 50 beds, this service connects families with intense residential mental health and behavioral health care to avoid relinquishment.

Medicaid is a jointly funded state-federal healthcare program that delivers healthcare services to vulnerable Texans, low-income children, pregnant women, children and youth, and foster care. CHIP is a state and federal program that provides subsidized health insurance coverage for the children of income-eligible families. Both programs also fund mental health services and treatments for Texas children. These services include:

- Evaluation by a psychiatrist;
- Medication management;
- Counseling services (psychotherapy);
- Targeted case management;
- Mental health rehabilitation services, which provide support and education for those with mental illness;
- A variety of substance use services, including screening, brief intervention, and referral;
- Collaborative care model, which integrates behavioral health and primary care services with a primary care provider, behavioral health case manager, and psychiatric consultant; and
- Mobile crisis services within the mental rehabilitation benefit.

Several additional benefits will be rolled out in the coming months. Certified Family Partner is a service where individuals with lived experience raising a child with mental illness or substance use disorder can provide support to families facing similar challenges.[13] These partners are certified and supervised by qualified mental health professionals (QMHPs). Additionally, HHSC will soon implement "in-lieu-of-services,"[14] which will allow managed care organizations to use

[13] Ryan Van Ramshorst, Health and Human Services Commission, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.

[14] *"In lieu of services and settings" are specific types of services or settings where care can be rendered or substitutes for services or settings that can be paid for in Medicaid under a state's plan by 42 CFR §§ 438.3(e)(2) and 438.16.*

Medicaid funding for step-down services, filling the gap between "in-patient" care and outpatient or community-based services.

As part of efforts to address the needs of high-risk youth, Texas has funded and implemented crisis outreach teams and MST interventions to address this population before it reaches the juvenile and child welfare systems. These services are designed to be more cost-effective than institutional care and have proven to be successful in reducing violence and improving outcomes.

Along with the panoply of services available under publicly funded HHSC and academic medical institutions, the Texas Education Agency and HHSC also fund and support prevention-focused programs that drive awareness and opportunities for interventions. These include:

- **Mental Health First Aid:** Teaches community members how to identify, understand, and respond to signs of mental illness and substance use disorder (SUD). A total of 6,713 instructors, school district employees, university employees, and community members have been trained in FY23.

- **Statewide SUD prevention and intervention programs:** Provide strategies, training, outreach, and referrals to connect individuals and families to local support services.

- **MentalHealthTexas.Org**: A website where users can access resources and training modules for various mental health concerns. These resources aid Texans about behavioral health resources that may be accessible to improve their lives.

- **Turn To:** A statewide media campaign to provide Texas youth, young adults, and parents with resources to cope successfully with trauma, stress, and anxiety—which have been escalated by COVID-19 and health disparities.

- **Texas System of Care** (TxSOC) Grant School-Based Initiative: Teams of school-based providers provide services and supports with targeted interventions such as parent support groups, crisis and psychiatric services, suicide prevention education, and case-management services.

- **Non-Physician Mental Health Professionals** (NPMHPs): NPMHPs provide behavioral health resources, behavioral health training, training in grief and trauma and link students to behavioral health services and supports.

Witnesses emphasized that TCHATT is performing crucial screening and detection to mitigate future crises by focusing on those children who are at serious risk for future involvement in justice

or foster care-related systems. This helps students access services without requiring referrals, which can be challenging, especially in rural areas that lack access to trained professionals.[15]

Targeting Resources to the Highest Acuity

While current state resources are focused both on services and prevention efforts, there was debate among witnesses on the efficacy of that strategy and whether there are better, more fundamental approaches to address growth in conditions like anxiety and depression.

For example, Gorman noted that the emphasis on the "public health" approach to mental health and the push for widespread treatment can create unintended consequences. "It may lead children to feel something is wrong with them for experiencing normal emotions like boredom or anxiety," she said. Moreover, labeling social problems as mental health issues can reinforce the idea that children are passive victims of their circumstances rather than capable of overcoming challenges, she noted.

Keller and Lakey countered that the current approach to providing services through TCMHCC does provide targeted services to ensure that children with more acute conditions are screened and can be directed toward care to stave off future episodes as a child enters adolescence or young adulthood.

Lakey highlighted that parents whose children have received services through TCHATT are asked to participate in surveys related to the quality and efficacy of those services. "Overwhelmingly, the parents are telling us through the surveys that they're their kids are indeed better," as a result of using TCHATT, he said.

Members of the committee asked why there is not more focus on the root causes of the uptick in mental and behavioral health issues, including the growing number of Texas children diagnosed with autism and or other conditions that can manifest in aggressive behaviors in schools, which ultimately could lead to involvement in juvenile or child welfare systems.

Despite billions spent on research, there is still a lack of clear understanding of the causes of serious mental illness. Factors include genetics, environmental toxins, and high levels of adversity—such as abuse and neglect—which can lead to anxiety and depression. Medical disorders can mimic behavioral conditions and can be misdiagnosed.[16]

A more fundamental shift in the cultural landscape has left more families isolated and lacking community social safety nets, which historically were fulfilled by interconnected families and high

[15] Andy Keller, Ph.D., Meadows Mental Health Policy Institute and David Lakey, M.D., University of Texas System, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.
[16] Carolyn Gorman, Manhattan Institute, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.

degrees of parental involvement, which often address the precursors to many behavioral health conditions.[17]

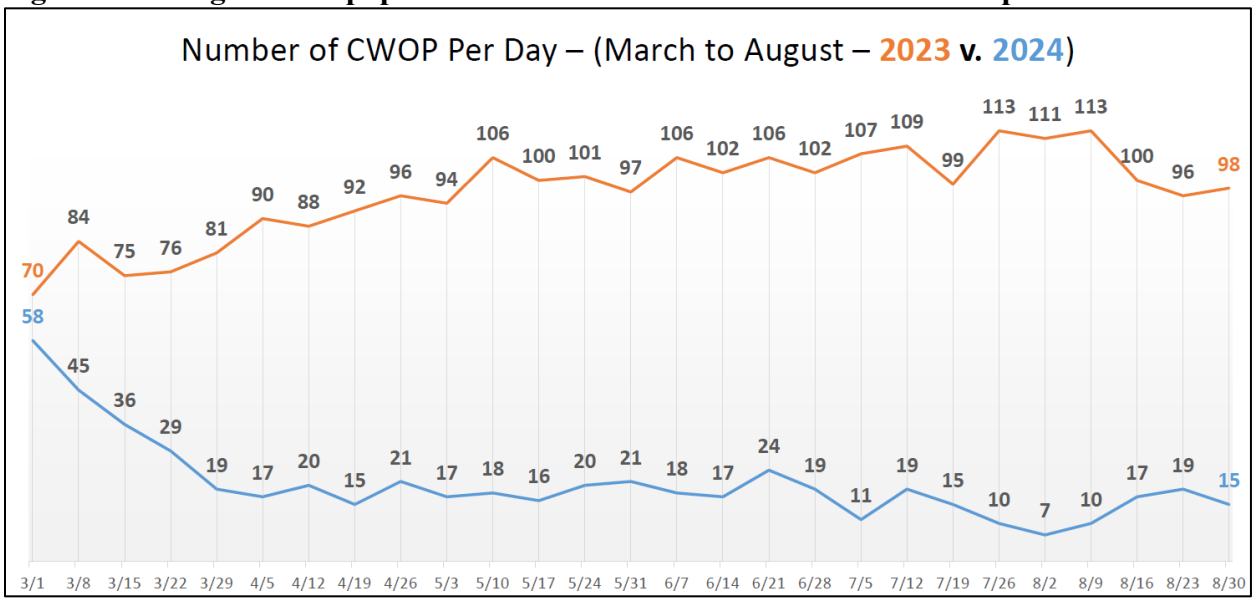
Moreover, in the absence of community, some state-funded programs can provide support that can mitigate future crises, according to Lakey. Programs like Nurse Family Partnership offer assistance to at-risk parents by providing free support and guidance on caring for young children, thereby preventing potential mental health issues later. TCMHCC continues to research the root causes of depression and suicide to better "identify missed opportunities for intervention."[18]

CWOP Children and High Acuity Children in Juvenile and Child Welfare Systems

DFPS provided data to address the trends within the population of children experiencing high behavioral health needs who lack foster placements.

Most CWOP youth are older adolescents, between 14 and 17 years old. Historically, they have stayed in DFPS offices or hotels, with DFPS staff providing 24-hour supervision. DFPS provided data reflecting the significant decrease in the CWOP population over the last year. Figures 7 and 8 demonstrate the decreases between the last fiscal years in average monthly CWOP and a snapshot of the average number per night by month.

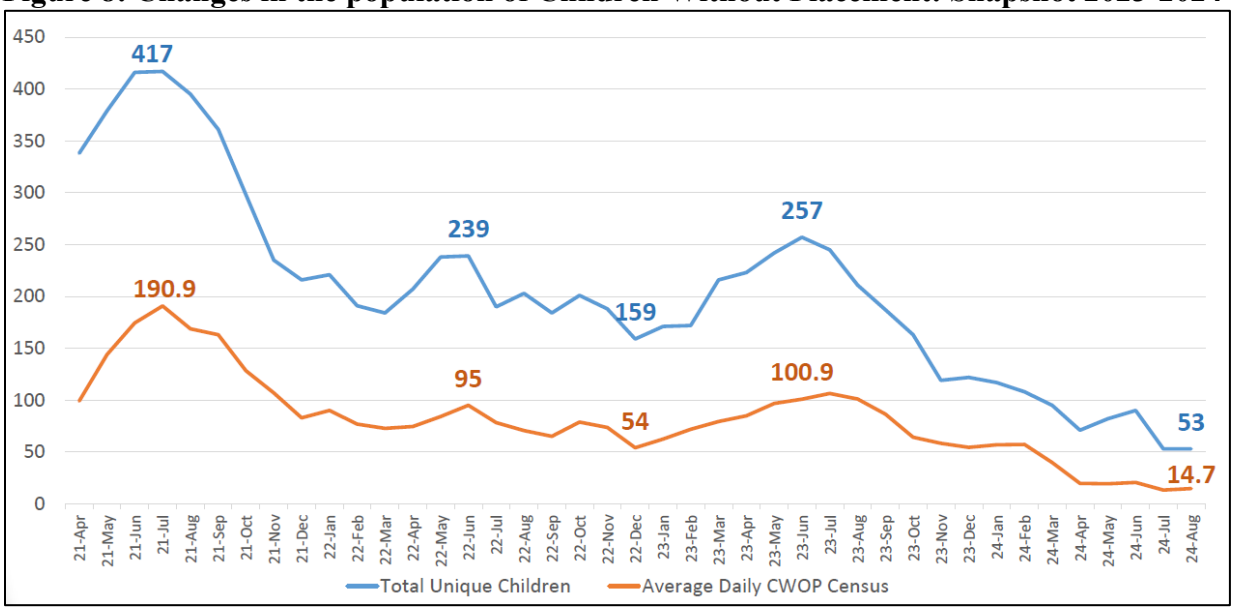
Figure 7: Changes in the population of Children Without Placement: Snapshot 2023-2024



***Source**: DFPS Presentation to Texas Senate Health and Human Services Committee*

[17] Andy Keller, Meadows Mental Health Policy Institute, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.
[18] David Lakey, University of Texas System, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.

Figure 8: Changes in the population of Children Without Placement: Snapshot 2023-2024



Source: *DFPS Presentation to Texas Senate Health and Human Services Committee*

DFPS has shifted from addressing the issue of CWOP from the "back end," which involved finding placements for high-acuity children, to a holistic approach to creating services or programs to address these youth before they need intensive care.

"We launched a pilot program for youth mentorship, connecting these kids with mentors who have walked a similar path," Muth said. Legislative funding supported intensive psychiatric stabilization programs have allowed the agency to tailor solutions for individual needs, she added. Collaboration among local mental health authorities, Medicaid, and DFPS residential providers is crucial to resolving these issues effectively.

In April 2024, DFPS leased a vacant residential treatment center to serve as a more permanent setting for boys aged 14 to 17 who lack licensed placements. This effort has moved children with higher behavioral needs to a stable environment, mitigating the need for temporary placements in settings such as hotels that may have inadvertently contributed to aggressive behaviors and created a barrier to treatments.[19]

DFPS also began an effort in March 2024 to track the living arrangements for youth no longer categorized in the "children without placement" population. The agency reported that roughly one-third of those children stepped down to a "home-based setting,"—whether in foster care, kinship placements, or therapeutic foster homes—marking a notable achievement.

Despite the decrease in children without placement, several challenges still exist. A significant proportion of youth experiencing time without placements are still coming from RAPR families,

[19] Stephanie Muth, Texas Department of Family and Protective Services, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.

demonstrating a need for community-based services that prevent these children from entering conservatorship.

Second, DFPS is facing a challenge in caring for children with longer-term needs. The agency has piloted in-patient services for these youth, but these options are often limited to those in DFPS conservatorship.

Finally, an additional lack of behavioral health providers who accept Medicaid remains a major issue for foster youth.[20]

Similarly, TJJD is attempting to find solutions for its growing high-acuity population. The agency received $200 million in funding to develop a psychiatric facility to serve children with high needs in the Juvenile system. However, one drawback to TJJD building out a state-run psychiatric facility is that it may reduce the incentive for communities to develop their own resources to prevent children from entering the state's juvenile system.[21]

Meanwhile, many Texas county probation departments around the state have communicated to the agency the need for a different type of residential setting for these children in order to provide more appropriate service and allow them to rehabilitate into the community. TJJD is requesting funding in the next budget cycle for a transitional independent vocational living program that can develop skills that allow a child to better complete vocational training and transition to community life after serving time. This initiative would operate in collaboration with probation departments in Dallas and Houston.

Finally, TJJD is struggling to hire appropriate staff to provide necessary oversight and services to more juvenile offenders with acute behavioral health needs. Carter told the committee that TJJD will request funding to boost direct-care staff salaries and hire additional specific staff, including special education and CTE teachers, wellness counselors, and support staff for determinate sentenced youth entering TJJD's custody.

Conclusion and Recommendations

Under previous investments in HHSC mental health services, local community mental health services, and academic health-related institutions, Texas has created a system to screen for more serious mental health issues within the child population through the TCMHCC. This screening aims to focus needed interventions and services on a voluntary basis on those children or adolescents with higher acuity.

[20] *Ibid.*
[21] Shandra Carter, Texas Juvenile Justice Department, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.

TCMHCC also supports efforts to train primary care physicians and other health care providers to help screen and target the mental health needs of children via the primary care system and to develop a strong workforce to address the needs of that population.

Previously funded services through the community mental health systems—including evidence-based services such as mobile youth crisis teams, multi-systemic therapy, and coordinated specialty care—are targeted and offered to both DFPS and TJJD and the general population.

Additionally, re-focusing state and local resources on the highest acuity populations, as opposed to funding a more broad-based, public health approach to mental health services, can address the pressing needs of children and avoid their entry into juvenile justice or foster care systems.

Witnesses suggested structural interventions that can provide respite for children from social media, technology devices, and other factors that are impacting rates of anxiety and depression among youth. Such interventions could include reinforcing full-day, in-person school classes, physical education, and daily recess in school and restricting access to social media apps or devices.

Finally, witnesses from HHSC, TJJD, and DFPS discussed the need for a specialized residential setting for children in conservatorship and the juvenile justice system that can fill the gap between in-patient hospitalization and community placement, as well as specific behavioral health services in the state's mental health system reserved for youth with dual IDD and behavioral health diagnoses in the custody of DFPS or TJJD.

INTERIM CHARGE II: ACCESS TO HEALTH CARE

Access to Health Care: *Evaluate current access to primary and mental health care. Examine whether regulatory and licensing flexibilities could improve access to care, particularly in medically underserved areas of Texas. Make recommendations, if any, to improve access to care while maintaining patient safety.*

Introduction

The Texas Senate Committee on Health and Human Services convened an interim hearing on September 18, 2024, to evaluate whether changes in the regulatory licensing for certain healthcare practitioners in Texas could increase access to healthcare services. The committee invited testimony from pharmacists, psychologists, doctors, economists, and regulatory boards, which allowed the committee to scrutinize corresponding bills from the 88th legislative session, which did not pass.

Herein, 'scope of practice' refers to the limitations on certain activities by licensed healthcare practitioners. Concern over the boundaries of various services provided by different types of practitioners remains fiercely debated. The committee's hearing focused on the most significant recent scope issues: advanced practice registered nurse (APRN) independent practice authority, pharmacists' ability to continue providing immunizations under the Public Readiness and Emergency Preparedness (PREP) Act, and prescription authority for psychologists.

Background

In 2024, 224 out of 254 counties in Texas were designated as health professional shortage areas, affecting six million Texans.[22] The Department of State Health Services (DSHS) projects future workforce supply shortages in Texas across nearly all primary care and mental healthcare providers.[23] The most recent projections found all primary care physician specialties will experience supply shortages through 2032.[24] Texas faces a pressing supply issue within its healthcare workforce that requires strategic intervention to address projected shortages.

During the 88th regular session, legislators filed several bills to amend the scope of practice authorities, including for APRNs, pharmacists, pharmacy technicians, and psychologist prescriptive authority.

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[22] Rural Health Information Hub. October 1, 2024. *Health Professional Shortage Areas: Primary Care, by County, October 2024-Texas*. https://www.ruralhealthinfo.org/charts/5

[23] Department of State Health Services. Texas Health Professions Resource Center. November 2024. https://www.dshs.texas.gov/center-health-statistics/health-professions-resource-center-hprc

[24] Texas Department of State Health Services. Texas Primary Care Office. March 2021. *Texas Primary Care Office Needs Assessment*. https://www.dshs.texas.gov/sites/default/files/chs/TPCO/2021%20Statewide%20Needs%20Assessment.pdf

The committee invited panels of expert witnesses to scrutinize the impacts of changing these licensing regulations on healthcare cost, quality, and access.

In Texas, doctors practice medicine and perform medical acts, and nurses practice professional nursing. Currently, *only* physicians are allowed to delegate medical acts to non-physicians. Even when a physician has delegated medical acts to a physician extender, all licensed health professionals are individually and professionally responsible for their conduct. The Board of Nursing's guidance on the APRN Scope of Practice clarifies that an APRN never functions under another individual's license. Each licensing board is responsible for evaluating and enforcing complaints related to practitioners exceeding the scope of their licensing authority.

Summary of the Testimony

Three panels of invited witnesses provided testimony and debate surrounding the major scope of practice proposals, as well as providing testimony to present the committee with an overview of the state of primary and mental healthcare in Texas. The first panel of invited witnesses was invited to represent their health profession respectively and professional associations in the context of scope of practice. The first panel of invited witnesses represented the perspective of current healthcare practitioners. The second panel of witnesses were the board presidents of the relevant licensing boards for the medical, nursing, and behavioral health professions and provided context for the current licensing scope for each of these practice areas. [25] Finally, a third panel of experts communicated the impacts of changing licensing rules in other states.

State Medical and Mental Health Practitioner Supply Trends

Varun Shetty, chief state epidemiologist for the Texas Department of State Health Services, provided insights on Texas's healthcare workforce supply and demand projections. Current supply calculations consider provider numbers, hours worked, and retirements, while demand is influenced by population demographics and healthcare usage patterns. By 2036, a shortage of 12,793 full-time equivalent (FTE) physicians is expected, with primary care physician unmet demand rising from 36 percent in 2022 to 41 percent. While the number of primary care physicians increased by 22 percent from 2015 to 2023, the graduate medical education (GME) slots are insufficient to meet future demand.

A similar trend is observed in psychiatry, with a 32 percent rise in supply, however unmet demand is expected to grow from 38 percent to 51 percent. Though registered nurses and nurse practitioners are increasing in number, a shortage of licensed vocational nurses and a significant rise in demand for registered nurses are anticipated by 2036.

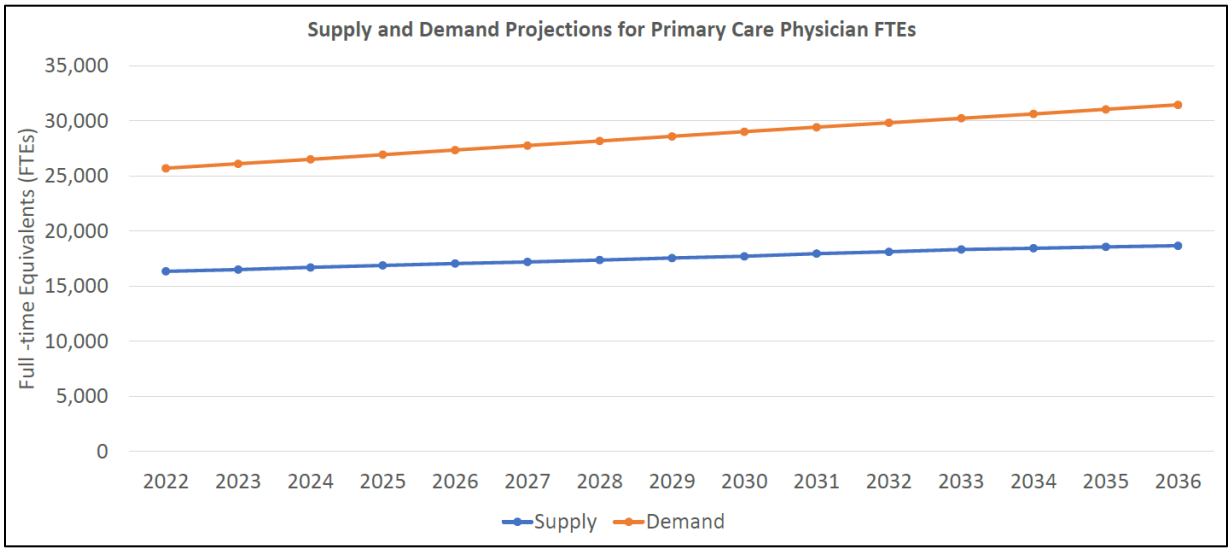
A nurse practitioner is a type of APRN. An APRN must first be licensed as a registered nurse (RN), and an APRN is licensed under a specific role, of which Texas has four: certified nurse practitioner (NP), certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), and clinical nurse specialist (CNS). Nurse Practitioners constitute the largest class of APRNs: in

[25] *See Appendix A.*

2023, there were 30,498 active NPs. In the same year, there were 4,037 CRNAs, 752 clinical nurse specialists, and 485 certified nurse-midwifes.

DSHS Nursing Workforce Studies Report indicates deficits in nursing professions, except for NPs and CRNAs. In 2023, there were 35,766 actively licensed APRNs in Texas, primarily nurse practitioners, but they were more concentrated in metropolitan areas. Only 5.8 percent of active APRNs reside in non-metro counties, reflecting disparities in access to care.[26] Figure 9 demonstrates that the demand for primary care doctors consistently exceeded supply throughout the data years (2022–2036).

Figure 9: Supply and Demand Projections for Primary Care Physicians



***Source**: Texas Department of State Health Services*

In *Nurse Supply and Demand Projections 2018-2032*, the Texas Department of State Health Services (DSHS) forecasts a shortage of licensed vocational nurses (LVNs), registered nurses (RNs), and nurse midwives by 2023. Conversely, NPs and CRNAs are projected to have an excess supply.

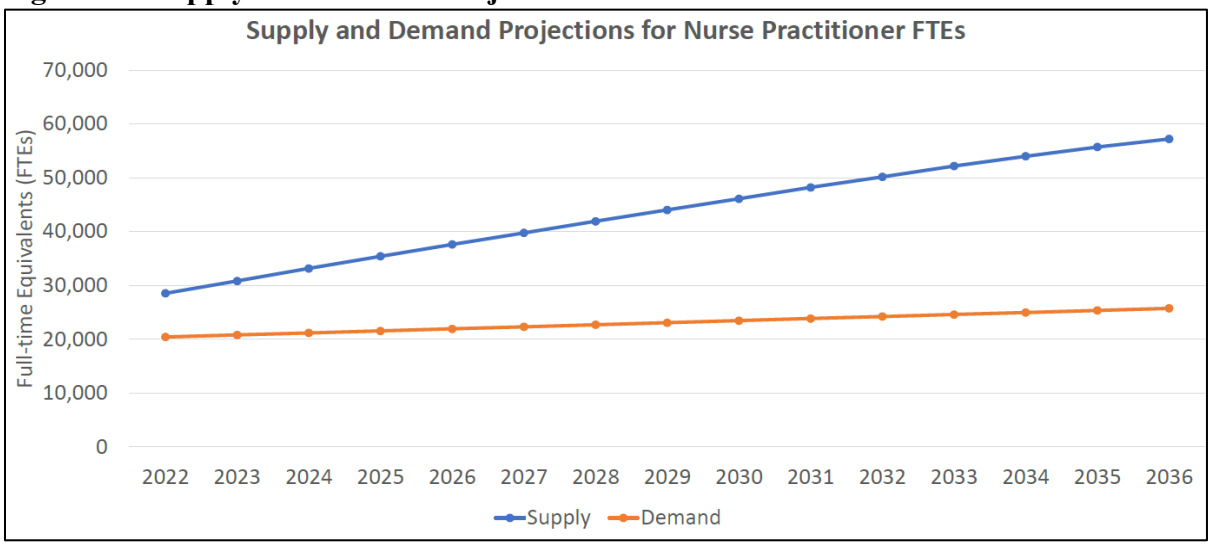
DSHS forecasts the following nursing workforce trends: [27]

- LVNs: Texas is projected to have a deficit of about 12,000 LVNs by 2032.
- RNs: Texas is projected to have a deficit of 57,000 RNs by 2032.
- NPs: Texas is projected to have a surplus of 19,271 NPs by 2032, with supply outpacing demand through 2036.
- CRNAs: Texas is projected to have a surplus of 3,221 CRNAs by 2032.

[26] Texas Department of State Health Services, *Supply of the Nursing Workforce,* September 2024. https://www.dshs.texas.gov/sites/default/files/chs/cnws/WorkforceReports/2023_Supply%20Report_accessible.pdf

[27] Varun Shetty, Texas Department of State Health Services, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.

Figure 10: Supply and Demand Projections for Nurse Practitioners



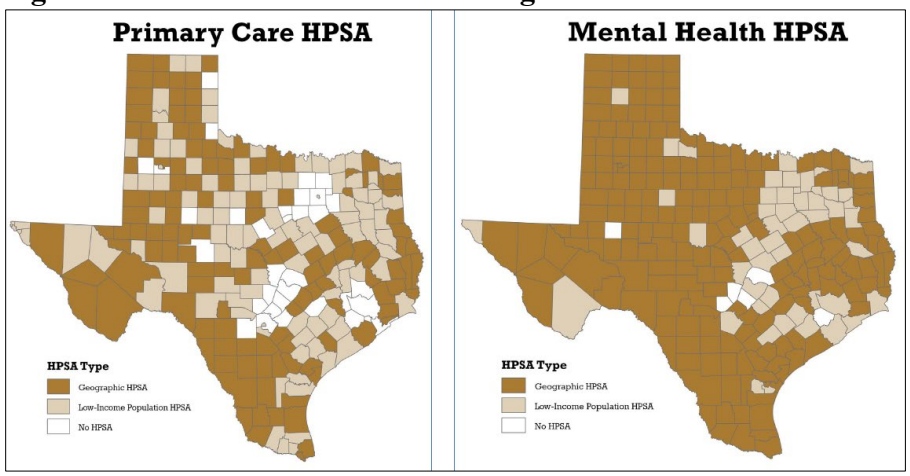
***Source**: Texas Department of State Health Services*

According to DSHS, Texas currently has a deficit of 1,728 psychiatrists and is projected to have a deficit of 3,310 psychiatrists by 2036. Psychiatry is identified as a critical shortage in all state regions except Central Texas. However, the supply of practicing psychiatrists increased by 32 percent from 2,013 in 2015 to 2,651 in 2023.

Health Professional Shortage Areas

The U.S. Health and Human Services Secretary designates health professional shortage areas (HPSAs) for geographical areas (whole or partial counties), population groups (low-income), and Facility types (FQHCs). Table 3 shows the primary care and mental health designations in Texas as of August 2024. A large segment of the state is currently designated as either a geographic or low-income population primary care HPSA. Nearly the entire state has a mental health HPSA designation.

Figure 11: Health Professional Shortage Areas



***Source:** Texas Department of State Health Services*

Consumer Protection under State Licensing Boards

A second panel of invited witnesses provided testimony to the committee on how licensing boards regulate physicians, nurses, psychologists, and pharmacists.

In Texas, practitioner competency is measured by the ability of the licensed individual to take care of patients. Table 1 reflects the boards are responsible for regulating healthcare professionals in mental and primary healthcare:

Table 1: Texas Health Licensing Boards

FY 2023	***Medical Board***	***Board of Nursing***	***Board of Pharmacy****	***Board of Psychologists***
New Licenses Issued	17,607	41,898	1,904 Pharmacists 503 pharmacies	666
Licenses Renewed	30,088	242,470	19,839 Pharmacists 3,779 pharmacies	4,984
Complaints Resolved	825	18,646	6,792	627
Budget Total	$14.3M	$13.5M	$10.1M	$4.8M
FTE Positions	224 FTEs	125 FTEs	110 FTEs	68 FTEs

***Source**: Data from TMB, BON, TSBP, and BHEC.*Not included under Board of Pharmacy are the "registered" pharmacy technicians: 20,976 new technicians and trainees registrations and 75,314 total registered technicians and trainees.*

Texas Board of Nursing

In Texas, the practice of nursing is regulated by the Texas Board of Nursing (BON), which oversees the licensure and professional standards for nurses licensed in Texas. The BON licenses LVNs, RNs, and APRNs.

Table 2: FY 2023 Texas Board of Nursing License Totals

FY2023	***New licenses***	***Renewal licenses***
LVN	4,619	44,703
RN	31,282	174,938
APRN	5,997	22,829
Total	41,898	242,470

***Source**: Texas Board of Nursing*

Kathy Shipp, president of the Texas Board of Nursing, testified that BON licenses more than 560,000 people, of whom 50,000 are APRNs.

Texas has taken steps to address nursing shortages by significantly funding various programs. The Texas Higher Education Coordinating Board oversees initiatives like the Nursing Shortage

Reduction Program, Nursing Faculty Loan Repayment Program, and Nursing Innovation Grant Program to boost the supply of registered nurses.

In the 88th Legislature, $23.4 million was allocated for the Professional Nursing Shortage Reduction Program and $12.5 million for nursing scholarships. The Nursing Innovation Grant Program received $6 million to support the education and retention of nursing students and faculty. Shipp emphasized BON's mission to protect patients and highlighted the benefits of Senate Bill 406 in streamlining collaboration with physicians and improving nurse practitioner education and mental health screenings.

Currently, Texas law gives the following flexibilities to improve access in rural areas of the state:[28]

- No numeric restrictions on the number of APRNs to whom a physician can delegate prescriptive authority or collaborate.
- No limit to the number of physicians who can delegate to an APRN.
- No on-site physical location requirements, which allows physicians and APRNs to collaborate without the necessity of being on-site or in close proximity.
- Monthly documented meetings between the APRN and physician are required, although the physician need not share the same specialty or be located in the same region.
- A monthly chart review is also required, accounting for one percent of patient reviews and averaging one hour in duration.

Nursing Scope Legislative History

Senate Bill 532 (81R) revised the requirements for delegating prescriptive authority to APRNs and physician assistants (PAs). It mandates that physicians and PAs register with the Texas Medical Board (TMB) when delegating this authority, requires on-site supervision of APRNs, and increases the number of APRNs a physician can supervise from three to four.

In 2013, Senate Bill 406 (83R) allowed APRNs to prescribe Schedule II drugs in specific facilities, provided they have prescriptive authority and appropriate physician delegation for emergency department, hospital, or hospice patients.

In 2019, House Bill 278 (86R) removed the in-person meeting requirement for new delegation agreements signed after September 1, 2019, allowing for the method of monthly meetings to be determined by the APRN and delegating physician. Monthly chart reviews between the physician and APRN can now occur electronically.

Texas State Board of Pharmacy

The Texas Board of Pharmacy (TSBP) enforces the Texas Pharmacy Act, overseeing 41,471 pharmacists, 8,369 pharmacy facilities, and 81,737 registered pharmacy technicians (including

[28] Kathy Shipp, Texas Board of Nursing, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.

15,661 trainees). Board President Julie Spier, a licensed pharmacist, highlighted the qualifications for becoming a pharmacist and pharmacists' scope of practice.

Table 3: FY 2023 Texas State Board of Pharmacy License Totals

FY2023	***New licenses***	***Renewals***	***Total licenses***
Pharmacists	1,904	19,839	41,471
Pharmacy Facility	523	3,779	8,369
Pharmacy Technicians and Trainees	20,976	18,300	75,314

Source*: Texas State Board of Pharmacy*

The Texas Pharmacy Act provides the following scope of practice duties: dispensing prescriptions, interpreting or evaluating prescription or medication orders, participating in drug or device selection, drug regimen review (this is looking for duplication of therapy, drug interactions, appropriateness of dosing), labeling, patient counseling, drug administration, immunization or vaccination under a physician's written protocol, compounding, drug therapy management (helping with adherence, calling patients), safely and properly storing drugs and devices, and maintaining proper records for drugs and devices.[29]

Board President Spier testified that that the federal Public Readiness and Emergency Preparedness (PREP) Act allows pharmacists in all 50 states to administer COVID-19 and seasonal influenza vaccines to individuals three years of age and older and allows pharmacy technicians to be delegated authority to immunize. These current authorities will expire on December 31, 2024.

Jay Bueche, a pharmacist and former president of the Texas Pharmacy Association, testified about expanding healthcare access by continuing to allow pharmacies to administer immunizations, currently allowed under the PREP Act. Pharmacists administered two-thirds of flu shots in Texas and 88 percent of vaccines for rural adults in 2021, according to Bueche.

Pharmacy Scope Legislative History

House Bill 1105 (88R) sought to extend the PREP Act, enabling pharmacists to order and administer vaccinations to patients three years of age and older, or to younger patients under a physician's written protocol. It would have also allowed pharmacists to delegate vaccination administration to pharmacy technicians.

In 2023, the Legislature considered but did not pass House Bill 2079 (88R), which sought to grant pharmacists the authority to perform CLIA-waived tests and prescribe medications.

Additionally, House Bill 343 (88R), known as the Psychologist Rx Authority Act, proposed that qualified psychologists be allowed to order, administer, or dispense non-opioid prescription drugs for certain disorders, disabilities, or illnesses.

[29] Julie Spier, Texas State Board of Pharmacy, *Testimony before the Texas Senate Health and Human Committee,* , September 18, 2024.

Texas Medical Board

The Texas Medical Board (TMB) is responsible for licensing and regulating physicians and physician assistants and is critical to ensuring standards of care, patient safety, and professional accountability in the practice of medicine. Each year, TMB reports record-breaking numbers of new licenses issued:[30]

Table 4: FY 2019-2023 Texas Medical Board New Physician Licenses

FY	***Number of New Physician Licenses***
2019	4,725
2020	4,862
2021	5,304
2022	6,584
2023	7,060*

Source: *Data from the TMB. *In FY23, TMB issued 1,607 licenses via the compact licensing pathway, constituting 23 percent of total licenses issued in FY23.*

Zaafran, president of the Texas Medical Board (TMB), testified on TMB's role in maintaining the highest level of professional standards for physicians and TMB licensees. He testified regarding the importance of a collaborative care team model led by physicians. Zaafran addressed physician workforce challenges, including provider shortages and geographic access, but stressed evidence-based solutions rather than solely looking at workforce distribution. He clarified misconceptions about the physician/APRN supervision and delegation requirements, clarifying that no payment is mandated for maintaining delegation relationships. He testified that current regulations are designed to ensure patient safety and quality care, while also acknowledging the role of APRN in a collaborative environment.

Zaafran discussed the TMB's enforcement processes, noting that complaints about APRNs often go to BON. He called for increased transparency regarding supervisory relationships and stressed the need for a consistent standard of care across providers. He concluded by reinforcing the physician's role in overseeing comprehensive patient care.

Texas State Board of Psychological Examiners

The Texas Behavioral Health Executive Council (BHEC) was created in 2019 by the 86th Legislature following the 2016–2017 Sunset review cycle to consolidate four behavioral health licensing boards under one agency. The Texas State Board of Examiners of Psychologists (TSBEP) was finally moved under one board during the 2019 session and began operations in 2021.

[30] Sherif Zaafran,M.D., "Message from the TMB President: Another Record-Breaking Licensing Year," *Texas Medical Board*, December 2023.
https://www.tmb.state.tx.us/dl/DCEFA6E0-E46C-CE3C-0A34-97E45A4D2E51

Table 5: FY 2023 BHEC License Totals

FY2023	*New licenses*	*Renewals*	*Total licenses*
Psychologists	340	2,660	5,900
Psychological Associates	37	386	800
LSSPs *(School Psychologists)*	289	1,938	4,400

Source: *Texas Behavioral Health Executive Council*

John Bielamowicz, Chairman of TSBEP, testified on the state's efforts to address challenges in mental health care, particularly for children and in rural areas. He highlighted the need for better workforce utilization and proposed solutions like loan forgiveness and prescriptive authority. Bielamowicz testified that a new requirement for a second licensing examination is being imposed by the Association of State and Provincial Psychology Boards and unnecessarily increases the barrier to entry. He recommended that Texas fund and develop a Texas-specific psychology licensing examination to enable the state to avoid the anticipated negative impact on the psychology workforce. He emphasized the Board's accountability that TSBEP is accountable to the public and is ready to collaborate on improving mental health services in the state.

Witnesses testified about the competencies and abilities of different healthcare professionals, and Table 6 provides an educational comparison of various healthcare professions, including the educational requirements, including degrees and licensure, and the estimated duration of training for each profession.

Table 6: Health-Care Profession Educational Comparison Chart

Profession	*Educational Requirements*	*Duration*
Doctor (MD/DO)	1. Bachelor's Degree (4 years) 2. Medical School (4 years) 3. Residency (3-7 years, varies by specialty) 4. Optional Fellowship (1-3 years, varies by specialty)	11-18 years (including optional fellowship)
Psychiatrist	1. Bachelor's Degree (4 years) 2. Medical School (4 years) 3. Residency in Psychiatry (4 years) 4. Optional Fellowship (1-2 years, varies by sub-specialty)	12-15 years (including optional fellowship)
Nurse (RN)	1. Diploma in Nursing (2 years) **OR** Associate Degree in Nursing (ADN) (2 years) **OR** 2. Bachelor of Science in Nursing (BSN) (4 years) 3. Licensure Exam (NCLEX-RN) Optional: Alternate entry Master's Degreee in Nursing (MSN) (2 years in addition to foundational nursing) for advanced roles.	2-6 years (depending on education path and optional MSN)
Advanced Practice Registered Nurse (APRN) – 4 roles ***1. Nurse Practitioner*** ***2. Nurse Midwife*** ***3. Clinical Nurse Specialist***	NPs, Midwives, CNSs must have foundational RN education and hold an active RN license. 1. Bachelor's Degree in Nursing (BSN) (4 years) 2. Master's Degree (MSN), Post-Master's Certificate, or Doctor of Nursing Practice (DNP) (2-4 years) 3. National Certification (varies by specialty) 4. Min. 500 hours - Direct patient care clinical hours in role and population focus.	6-8 years total (including 2-3 years post-baccalaureate degree; And 500 direct care minimum clinical hours as dictated by

Profession	*Educational Requirements*	*Duration*
4. Certified Registered Nurse Anesthetist (CRNA)		certification requirements.
Certified Registered Nurse Anesthetist (CRNA)	All CRNAs must have foundational RN education and hold an active RN license. 1. Bachelor's Degree in Nursing (BSN) (4 years) 2. Master's Degree in Nurse Anesthesia or Doctor of Nursing Practice (DNP) with a focus on Anesthesia (2-4 years) 3. Certification Exam (National Certification Examination) 4. Licensure	6-8 years (including MSN or DNP)
Licensed Vocational Nurse (LVN)	1. Vocational Nursing Program (1-2 years) 2. Licensure Exam (NCLEX-PN)	1-2 years
Psychologist	1. Bachelor's Degree (4 years) 2. Doctoral Degree (PhD, PsyD, and Ed.D.) (inclusive of internship and practicum) (5-7 years) 4. Postdoctoral Supervised Experience (1-2 years; post-docs are not required by every state 5. Licensure Exam	10-13 years
Pharmacist	PrePharm (2-4 years, depending if BS is obtained) 1. Bachelor's Degree (3 years in addition to Prepharm (no longer offered by Tx schools) 2. Doctor of Pharmacy (PharmD) (4 years in addition to PrePharm) 3. Licensure Exam (NABP and MPJE) Optional: Residency or Fellowship (1-2 years)	6-10 years (including optional residency or fellowship)

Source: *Texas Medical Board, Texas Behavioral Health Executive Council, Texas State Board of Pharmacy, Texas Board of Nursing*

State of Primary and Mental Healthcare Access

Witnesses representing various physicians, nurse practitioners (NPs), psychologists, and pharmacists provided input on how changes to the current licensing laws could impact access to primary health care services, especially in underserved parts of Texas. Currently, Texas law allows APRNs (including NPs) and other healthcare providers to practice direct patient care, including independently performing medical acts like ordering tests or prescriptions, so long as such acts are under the delegation of licensed physicians.

Holly Jeffreys, an APRN representing the Texas Nurse Practitioners Association, testified to the ability of APRNs to increase access to primary health care services in rural communities by allowing APRNs to practice under the full scope of their licensure.

In Texas, where licensed doctors retain the primary ability to practice "medical" acts, the effect of independent APRN scope of practice means medical acts can be performed by APRNs within their scope, role, population area, and competency but completely independent of a licensed physician.

Jeffreys stated that "76 percent of NPs are specializing in primary care" and psychiatric mental health.[31] To meet Texas's healthcare demands, Jeffreys recommended that Texas remove the delegation requirement and give NPs full authority to practice medical acts independently without the oversight of a physician.

To date, 27 states have elected to allow APRNs the authority to practice independently. To meet Texas's healthcare demands, Jeffreys recommended that Texas remove the delegation requirement and give NPs full authority to practice medical acts independently without the oversight of a physician.[32]

However, Dr. Ray Callas, president of the Texas Medical Association and a board-certified anesthesiologist, testified in support of the current legal framework requiring physicians to delegate medical tasks to physician extenders, like nurse practitioners, and highlighted potential drawbacks of independent nurse practice, which could affect cost and quality of care.

Additionally, Callas presented reasons to the committee for upholding the current regulatory regime between physicians and APRNs: APRN programs do not match the comprehensive training of physicians, who undergo four years of medical school education, three to seven years of residency, and 12,000 to 16,000 hours of clinical training. In comparison, NPs generally complete a master's degree in two-to-three years, have only 500 to 720 hours of training,[33] and may even take portions of their training online.[34]

Jeffreys testified that the current delegation protocol imposes regulatory burdens on nurse practitioners (NPs) by requiring them to find a delegating doctor, who will often charge a delegating fee. Following the passage of House Bill 278 (86R), the current delegation protocol only requires a monthly meeting or a phone call with the delegating physician, and the physician need not be on-site.[35] Thus, she testified the current "full practice laws [have] zero impact on patient safety". She cited one 2023 study by Texas A&M University that found that APRNs represented only two percent of all malpractice cases in Texas and nationally over a 30-year period, whereas physicians represented 98 percent of the claims.[36]

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[31] Holly Jeffreys, Texas Nurse Practitioners Association, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.
[32] Holly Jeffreys, Ray Callas, M.D., *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.
[33] Ray Callas, M.D., Texas Medical Board, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.
[34] Holly Jeffreys, Texas Nurse Practitioners Association, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.
[35] H.B 278, 86th Legislature, Regular Session, 2019.
[36] Bolin, J.N., Cline, K., Carruth, L., Horel, S., "Long-Term Financial & Public Health Benefits of Full Practice Authority for APRNs," Texas A&M University (2023): https://cdn.ymaws.com/texasnp.site-ym.com/resource/resmgr/media/tnpf_research_study_2023_fin.pdf

By contrast, Callas cited other recent studies indicating that independent nurse practitioners may lead to lower care quality and higher preventable hospitalization rates, which, in time, can drive up healthcare costs.[37]

Witnesses also discussed the scope of practice issues related to Pharmacies and pharmacists. Invited witnesses testified on extending the temporary federal authorities for pharmacists and pharmacy technicians under the PREP Act, which expires at the end of 2024. Jay Bueche, representing H-E-B, testified on the role of pharmacies in Texas in providing greater access to care, and especially during the COVID-19 public health emergency. He testified that Texas would be one of only six states not to allow pharmacy technicians to administer immunizations, should the temporary federal authorities under the PREP Act expire without legislative action.

The committee also heard testimony on proposals to expand pharmacists' authority to order certain diagnostic tests and treatments, commonly referred to as Test-and-Treat. Callas raised concerns about allowing pharmacists to diagnose based on lab tests, citing potential risks to patient safety, and urged committee members to maintain current care standards while fostering collaboration among healthcare providers.

The committee also heard testimony on proposals to allow psychologists to order prescriptions for patients. Hani Talebi, Ph.D., representing the Texas Psychological Association, discussed psychologists' lack of prescribing authority under current Texas law, which permits only psychiatrists to prescribe medications. He emphasized that psychologists possess extensive training in managing psychotropic medications and urged the legislature to consider expanding their prescriptive authority to improve mental healthcare through a collaborative approach.

Dr. Thomas Kim, M.D. testified on behalf of the Texas Medical Association and the Federation of Texas Psychiatry against expanding prescriptive authority for psychologists. He suggested focusing on telehealth to enhance access to care and invited further discussions on improving mental health services in Texas.

Economics of Practitioner Licensing

John C. Goodman, president, and CEO of the Goodman Institute for Public Policy Research, testified on the potential economic impacts of expanding the scope of practice authorities for Nurse Practitioners. He testified on the healthcare workforce shortage in the U.S., emphasizing that increased funding on the demand side has not improved access to care. He noted that Texas's restrictions on nurses' practice without physician supervision limit access to essential healthcare providers, particularly in rural areas. Goodman advocated for allowing nurses to practice to the full extent of their training, citing positive evidence from studies.

Alicia Plemmons, assistant professor and director of health research at West Virginia University, testified on the impact of full practice authority for nurse practitioners (NPs) on healthcare access and outcomes. She cited studies that show how states that allow full practice authority experienced

[37] Bryan Batson, Samuel N. Crosby, John M. Fitzpatrick, "Targeting Value-based Care with Physician-led Care Teams," *Journal of the Mississippi State Medical Association*, Vol. LXIII, No. 1 (January 2022) 19-21. https://ejournal.msmaonline.com/publication/?m=63060&i=735364 &p=21&ver=html5

an increase in NP recruitment, with an expected six percent rise in primary care providers, benefiting both urban and rural areas.[38]

To the contrary, Rebekah Bernard, a family physician from Florida who testified on behalf of the Texas Medical Association, asserted that states with independent NP practice have not seen significant improvements in rural healthcare access and noted a trend of NPs moving to urban areas instead. Citing evidence of increased unnecessary prescriptions[39] and a lack of rigorous training among NPs, particularly those entering the field through direct entry programs,[40] Bernard expressed concerns over the quality of care provided by independent NPs.

She testified that studies demonstrating the effectiveness of nurse practitioners also involve supervision by physicians, not NPs practicing alone, and emphasized the importance of physician collaboration and involvement in the medical care team.

Conclusion and Recommendations

By 2050, Texas is projected to have more than 50 million residents but will have deficits across several healthcare provider types.[41] Through the three panels of invited expert witnesses, the committee heard from state regulatory boards, healthcare clinicians, and economists who identified potential costs, current gaps, and forecasted needs of the state, particularly with respect to accessing primary and mental healthcare.

Texas currently relies on the expertise of the health licensing boards to ensure the highest level of patient care is delivered to the greatest number of people. When licensed practitioners fall short of state law or board rule, the licensing boards hold their licensees accountable to the fullest extent allowed by law. Witnesses urged members to continue to invest resources to ensure all licensed healthcare professionals are providing the highest level of care and support through necessary appropriations to the regulatory licensing boards that enforce statutory requirements and professional standards

Additionally, the committee chair discussed the need for the state to maintain unified and consistent standards of care and avoid creating differing standards based on who is providing the care rather than for the care itself.

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[38] Shishir Shakya, Alicia Plemmons, "Does Scope of Practice Affect Mobility of Nurse Practitioners Serving Medicare Beneficiaries?" *Journal of Labor Research* 41 (November 15, 2020), p.421–434. https://doi.org/10.1007/s12122-020-09308-1

[39] David C. Chan Jr, Yiqun Chen, "The Productivity of Professions: Evidence from the Emergency Department," *Working Paper*, National Bureau of Economic Research (2022).

[40] Joe Tabor, Nick Jennings, *et.al.,* "The Supply of Physician Assistants, Nurse Practitioners, and Certified Nurse Midwives in Arizona," Center for Rural Health Mel and Enid Zuckerman College of Public Health The University of Arizona, June 2014.

[41] Texas Demographics Center, "*Texas Population Projections 2010 to 2050*," September 2019. https://www.demographics.texas.gov/Resources/TDC/Publications/2019/2474/20190925_TexasPopulationProjections20102050.pdf

Yet some committee members questioned how oversight should be administered for NPs who perform medical services, and what standard of care would be applied if delegation authority is removed. Currently, NPs would be held to complaints under the Texas Board of Nursing and not the Texas Medical Board, but the supervising physician could be held liable if the NPs invited that physician to review the case.[42]

Several committee members expressed concerns related to the number of nurse practitioners who provide full-practice services with intermittent oversight. Witnesses acknowledged that some NPs are delegated via online supervision or once-a-month with a retrospective review in exchange for the delegation fee.

Additional policy solutions to address workforce shortages must prioritize rural and underserved areas of the state and support measures that strengthen affordability and access to care. Lawmakers could consider examining the current financial structures of delegatory agreements between nurse practitioners and physicians to ensure that delegation fees charged are not excessive and are commensurate with the level of delegation oversight provided.

New, standardized educational requirements—including a residency-like requirement—might be established to enable NPs/APRNs to practice more independently, ensuring consumers are protected and rural regions can gain additional providers.

Despite the differences of opinion expressed by the panels, one trend emerged throughout: witnessed urged continued collaboration among nurses, pharmacists, physicians, and psychologists to enhance patient care and optimize resources for healthcare services.

Additionally, while there are surpluses for the forecasted number of nurse practitioners, Texas is still in need of registered nurses and licensed vocational nurses. Lawmakers should consider measures to address those shortages and continue efforts to train more physicians.

Finally, Texas BHEC and the State Board of Psychologists should continue to prepare options to mitigate against the uncertain future availability of the sole psychology licensing examination.

[42] Holly Jeffreys, Texas Nurse Practitioners Association, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.

INTERIM CHARGE III: HEALTH INSURANCE

Health Insurance: *Examine the Texas health insurance market and alternatives to employer-based insurance. Identify barriers Texans face when navigating a complex health insurance market. Make recommendations that help individuals obtain healthcare coverage.*

Introduction

The Texas Senate Committee on Health and Human Services held an interim hearing on May 14, 2024, to consider the state of Texas' health insurance market and examine the availability, cost, and alternative market-based solutions to rising health insurance costs.

Background

Health insurance premiums' cost for employees and employers continues to grow. The most recent data show the average family premium in Texas is $23,968 annually, a seven percent increase from 2022. In employer-sponsored health plans, the total annual premium is usually shared between the employer and the employee. In light of the growing cost of health insurance and issues of affordability, the committee examined the current barriers facing health insurance affordability and access.

Summary of the Testimony

The Texas State agency responsible for regulating the business of insurance is the Texas Department of Insurance (TDI), led by Commissioner Cassie Brown, who was appointed by Governor Abbott in 2021. For purposes of health insurance, TDI regulates fully insured health insurance plans, including plans sold via the federal insurance exchange Healthcare.gov, which impacts approximately 17 percent of Texas consumers. Texas law exempts the following from TDI's regulation: Medicaid, health plans for state employees and retired teachers (i.e. ERS & TRS), university employees, church employees, and city and county employees.[43] Under federal law, Texas has almost no ability to regulate federal plans such as traditional Medicare and TRICARE, uniformed service members, retirees, and their families. TDI does not regulate self-funded or self-insured employer-sponsored health plans (the majority of employer plans), and air ambulance services.[44]

TDI regulates over 3,400 insurance companies and resolved more than 17,000 consumer complaints in the last fiscal year, resulting in over $58 million in additional claim payments and refunds.

[43] *Ibid*
[44] *Ibid*

Health Insurance Background

TDI regulates fully insured plans for major medical product types, including health maintenance organizations (HMOs), point of service (POS) plans, preferred provider organizations (PPOs), Exclusive Provider Organizations (EPOs), and short-term health plans.

TDI regulates the health insurance market by checking finances, reviewing rates, approving forms, and ensuring networks are adequate. Plans on the Exchange must meet Texas rules. TDI helps consumers with complaints and enforces policies, even for ACA Exchange plans. TDI also regulates more than 3,400 insurance companies, issues more than 900,000 agent and adjuster licenses, and responds to consumers' questions and complaints. TDI's financial division ensures that health insurers have enough funds to pay claims, while the fraud division protects Texans from fraud. Recently, enrollment in the individual market grew from 1.1 million in 2020 to an estimated 3.3 million in 2024. [45]

Since regulation of health insurance is shared between states and the federal government, a common source of confusion among public consumers is who regulates what types of insurance, especially for those who receive coverage through their employer coverage.

Under the Employee Retirement Income Security Act of 1974 (ERISA), private-sector employee health benefit plans are subject to federal regulations (rather than state regulations), and states are expressly preempted from legislation that regulates ERISA plans, although increasingly states are challenging ERISA-preemption[46].

In Texas, TDI regulates fully insured health insurance plans, including plans sold via the federal insurance exchange, ***Healthcare.gov***, which impacts approximately 17 percent of Texas consumers. Generally, TDI regulates plans, including short-term plans, limited benefit plans, and Medicare Supplement plans.

Texas statute was crafted to exempt several types of insurance from TDI's regulatory authority, including Medicaid, health plans for state employees and retired teachers, health plans for university employees, church employees, and city and county employees.[47]

Under federal law, Texas has little to no ability to regulate federal plans such as Traditional Medicare and TRICARE, which covers uniformed service members, retirees, and their families. TDI does not regulate self-funded or self-insured employer-sponsored health plans (the majority of employer plans), and air ambulance services.[48]

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[45] Cassie Brown, Texas Department of Insurance, *Testimony before the Texas Senate Committee on Health and Human Services*, May 14, 2024.
[46] Bloomberg Law. December 2023. *Employer Health Plans Fear State PBM Crackdown Preemption Threat.* https://news.bloomberglaw.com/daily-labor-report/employer-health-plans-fear-state-pbm-crackdown-preemption-threat
[47] Cassie Brown, Texas Department of Insurance, *Testimony before the Texas Senate Committee on Health and Human Services*, May 14, 2024.
[48] *Ibid.*

A common source of confusion among public consumers is 'which entity regulates what types of insurance." This is especially nuanced when dealing with 'ERISA Plans,' which are generally preempted from state regulation. Since the 1974 enactment of The Employee Retirement Income Security Act[49] (ERISA), private-sector employee health benefit plans are subject to federal regulations rather than state regulation, and states are expressly preempted from legislating ERISA plans to create a harmonious regulatory environment for businesses rather than allow a patchwork of state-specific mandates.

Additionally, since the Health Insurance Portability and Accountability Act of 1996 (HIPPA), the federal government has substantially increased its regulatory role in the health insurance marketplace. Finally, the Patient Protection and Affordable Care Act of 2010 (ACA) implemented significant reform in the individual market and established comprehensive minimum plan standards and subsidies to help consumers afford coverage.

Consumer Education

Consumer education is important given the complex and nuanced nature of health insurance. In view of the need to help shoppers make informed decisions, Commissioner Brown testified on TDI's consumer-facing resources available to the public. TDI hosts a cost comparison site, TexasHealthCareCost.org, where consumers can compare medical procedure costs across the state. HelpInsure.com helps users find and compare property and casualty coverage. TDI also shares blogs, podcasts, and videos to guide consumers on insurance, claims, and scams. Other states have asked to use TDI's materials for their own education efforts.

The Office of Public Insurance Counsel is an independent agency charged with representing the interests of consumers in matters of insurance. In light of the role of the Office of Public Insurance Counsel, David Bolduc testified on the office's key functions: regulatory work, legislative support, consumer education, and board service. Bolduc explained that his office helps consumers through a helpline and collaborates with TDI to identify and solve problems. He discussed barriers in the insurance market, including high costs, perceived costs, lack of transparency, and complexity of information. He said that many people may qualify for low-cost health plans under the Affordable Care Act but often find the system confusing. Bolduc suggested that there is a need for better coordination among state resources and emphasized grassroots outreach to target lower-income groups. He recommended more resources to improve consumer tools and enhance collaboration between agencies. [50]

Key factors driving these costs include higher healthcare utilization, increased demand for services and drugs, rising labor costs related to staffing shortages, consolidation in the healthcare sector, and a shift toward level-funded plans among small employers.

[49] U.S. Department of Labor, *Employee Retirement Income Security Act (ERISA). Accessed November 21, 2024*. https://www.dol.gov/general/topic/retirement/erisa.

[50] David Bolduc, Texas Office of Public Insurance Council, *Testimony before the Texas Senate Committee on Health and Human Services*, May 14, 2024.

Exchange Plan Enrollment

Commissioner Brown testified that the growth in enrollment in exchange plans in Texas (authorized by the Affordable Care Act): Commissioner Brown noted, "the individual market has grown significantly in recent years, from 1,100,000 in 2020 to an estimated 3,300,000 in 2024."

The committee also examined the growth in enrollment in the individual market. As of 2024, 20.5 million people are enrolled in ACA plans nationwide, and Texas accounts for 3.4 million enrollees.[51] Brown testified, "The percentage of individuals buying coverage has increased from three percent of Texans in 2010 to nine percent in 2023".." Several factors contribute to growth in the individual market:

In 2021, Texas passed Senate Bill 1296 (87R), which required TDI to "take over rate review from CMS for exchange plans, update geographic rating areas, and standardize silver-loading."[52]

The American Rescue Plan of 2021, extended by the Inflation Reduction Act, has enhanced subsidies for those earning above 400 percent of the federal poverty level until 2025, which has also contributed to enrollment. ACA mandates include guaranteed coverage and essential benefits such as emergency services, mental healthcare, and preventive services.

Brian Blase, president of the Paragon Health Institute, told committee members that Texas must pursue policies that empower patients and reform the current healthcare regulatory regime. He explained that initial enrollment in health insurance plans under the requirements of the federal Affordable Care Act (ACA) was lower than predicted, and insurance premiums actually rose as a consequence of the new regulations, which was counter to the marketing of the legislation.

Blase also discouraged the expansion of Medicaid to individuals below 138 percent of the federal poverty level and testified that should Texas expand Medicaid; the state could be responsible for $7,000,000,000 in additional annual costs. "If Texas were to expand Medicaid, the state's Medicaid enrollment would increase by more than 3 million recipients."[53]

Blase also cited issues seen in other states that expanded Medicaid, including higher spending, waste, and reduced access to care for existing Medicaid recipients. He proposed reforms for Texas, such as reference-based pricing in state employee plans and expanding options for small employers to improve healthcare access and competition. [54]

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[51] U.S. Department of Health and Human Services, Office of Health Policy, Assistant Secretary For Planning and Evaluation, "Health Coverage Under the Affordable Care Act: Current Enrollment Trends and State Estimates," March 22, 2024. https://aspe.hhs.gov/reports/aca-related-enrollment-february-2024

[52] Cassie Brown, Texas Department of Insurance, *Testimony before the Texas Senate Committee on Health and Human Services*, May 14, 2024.

[53] Brian Blase, Paragon Health Institute, *Testimony before the Texas Senate Committee on Health and Human Services*, May 14, 2024.

[54] *Ibid.*

Alternatives to Fully Insured and Fully Self-funded Insurance

The committee heard invited testimony on addressed alternatives to the fully insured market (subject to TDI requirements) and traditional fully self-funded insurance (subject to ERISA/federal requirements).

Direct Primary Care (DPC) was authorized in Texas in 2015 through House Bill 1945 (84R). DPC allows patients to contract directly with physicians and pay a membership fee for a set range of services. This model includes care coordination to help patients access discounted services, such as lab tests. While DPC is recognized in Texas, it is not regulated by TDI since it is classified as a non-insurance model.

The Texas legislature in 2021 authorized Texas Mutual to write 'level-funded plans," which are a hybrid category under self-funded plans. Texas Mutual Health Plan (Texicare) offers level-funded plans for businesses, which are categorized as ERISA plans. These plans are authorized under Chapter 2054 of the Texas Insurance Code and are regulated by the U.S. Department of Labor, not TDI.

As of May 1, 2024, no lives were covered under Texicare, but Texas Mutual is expanding its networks in West Texas and El Paso. Other insurance carriers, such as UnitedHealth, also sell level-funded plans to employers. [55]

Healthcare sharing ministries operate under Chapter 1681 of the Texas Insurance Code and are regulated by the Office of the Attorney General, which addresses complaints. Healthcare sharing ministries was authorized in Texas through Senate Bill 8774 (84R). Health sharing ministries are tax-exempt organizations that facilitate the sharing of healthcare costs among members of similar faiths, resembling crowdfunding.

Conclusion and Recommendations

Witnesses discussed ways that Texas can encourage additional consumer education of health care options TDI and the Office of the Public Insurance Counsel should continue their ongoing commitment to educate the public on health insurance affordability and product options, but also expand their efforts to inform the public by publishing a booklet consolidating new and existing TDI health insurance content to help inform consumers regarding the basics of health insurance.

Texas should encourage healthcare prices to be available for consumers as widely as possible, including requiring healthcare providers to make accessible list prices to incentivize consumers shopping for coverage.

Finally, efforts to increase available health insurance coverage types under innovative, alternative, private market options for healthcare services can provide options to small businesses and individuals. Texas policymakers could also encourage the federal government to enact tax policies

[55] Meredith Duncan, Texicare, *Testimony before the Texas Senate Committee on Health and Human Services*, May 14, 2024.

that encourage wide use of health savings accounts and other financing options that give consumers more freedom in the healthcare markets.

INTERIM CHARGE IV: CANCER PREVENTION

Cancer Prevention: *Identify and recommend ways to address the growing impact of cancer on Texans by evaluating state investments in cancer prevention and screenings including, but not limited to, "CT," "MRI," and "PET" scans. Study and make recommendations on funding adequacy for prevention efforts at the Cancer Prevention and Research Institute of Texas (CPRIT).*

Introduction

The Senate Health and Human Services Committee conducted an interim hearing on May 14, 2024, to investigate new tools, technologies, and other public health interventions that might address the increasing number of Texas residents diagnosed with cancer. In particular, the committee sought to learn whether new diagnostic tools could screen cancer cells sooner and if the current state investments in cancer prevention strategies related to such tools or technologies could help reduce the rates of cancer.

Experts from state agencies and academic institutions were invited to testify and to educate the members of the committee how Texas is currently tracking cancer incidence at the Department of State Health Services Cancer Registry, how it is addressing cancer prevention through investments in the Cancer Prevention and Research Institute of Texas, and how the state could further address growing rates of cancer through other public health initiatives.

Background

Cancer has long been a focus of the state of Texas's disease prevention, anchored by efforts to tracks its prevalence and increase research funding for treatment and care. Cancer is the leading cause of death for Texans under 35 years of age, and kills more children and adolescents than any other disease.[56]

Cancer also represents a major cost to the state. According to the economic research organization, the Perryman Group, the direct cost of cancer in Texas was almost $56.3 billion in 2023, with total economic losses including multiplier effects amounting to $148 billion in lost output and 1.3 million jobs.[57]

Cancer Prevention and Research Institute of Texas

The Texas Legislature created the Cancer Prevention & Research Institute (CPRIT) in 2007, a $6 billion, 20-year initiative, to spearhead cancer research and prevention. It is the largest state-based cancer research investment in the United States, and the second largest public source of funding for cancer research behind the National Institutes of Health.

[56] Kristen Doyle, Cancer Prevention and Research Institute of Texas, *Testimony before the Texas Senate Committee on Health and Human Services*, May 14, 2024.
[57] *Ibid.*

CPRIT has funded 1,967 awards for cancer research, product development, and prevention since 2010. The total amount awarded as of this writing is $3,542,257,795. During the 88th legislative session, CPRIT funded 174 awards valued at $276,993,514, as follows:

- Academic Research (118 awards) valued at $199,293,400
- Product Development Research (1 award) valued at $7,446,844
- Prevention (55 awards) valued at $70,253,270

While cancer treatments have improved and fatality rates are declining, the state is facing increased challenges in effectively preventing certain types of cancer and identifying those types in a timely manner to ensure effective treatment.

Cancer death rates have dropped by one-third from a peak in 1991 to 2021, thanks to declines in smoking, increased earlier detection and better treatments. Across the nation, cancer death rates have declined over the last quarter century due to a combination of evidence-informed actions, including "effective tobacco control due to public policy, education, and cessation assistance."[58]

However, recent data show that the incidence of cancer is rising, especially for individuals under 50 in the U.S. For example, diagnosis rates in the U.S. rose in 2019 to 107.8 cases per 100,000 people under 50, up 12.8 percent from 95.6 in 2000, according to the Centers for Disease Control and Prevention.[59]

Some cancer incident rates in 2020 dropped from 2019, largely from lack of covid-era screening, but are expected to rise. Treatment and survival rates are increasing thanks to better screening and detection.

The Texas Senate Committee on Health and Human Services convened a panel of experts from CPRIT, the Texas Department of State Health Services, the University of Texas MD Anderson Cancer Center, and independent research firm Synechion, Inc, in Dallas to discuss trends in cancer rates and treatments, and to make recommendations on how the state can encourage more prevention.

Texas Cancer Data and Statistics

The Texas Cancer Incidence Reporting Act, passed in 1989, established the requirements for cancer physicians and related professionals and hospitals to report incidence of cancer in Texas residents. In 1992, the United States Congress established the National Program of Cancer Registries (NPCR) through passage of the Cancer Registries Amendment Act and authorized the Centers for Disease Control and Prevention (CDC) to provide funding and technical assistance to state-based cancer registries as part of a national surveillance system.

The Texas Cancer Registry is a statewide population-based repository for every new cancer case in the state and part of a national surveillance system. It is one of the largest cancer registries in

[58] Ernest Hawk, M.D., M.P.H., The University of Texas MD Anderson Cancer Center, *Testimony before the Texas Senate Committee on Health and Human Services*, May 14, 2024.
[59] Brianna Abbott, "Cancer Is Striking More Young People, and Doctors Are Alarmed and Baffled," *Wall Street Journal*, January 11, 2024. https://www.wsj.com/health/healthcare/cancer-young-people-doctors-baffled-49c766ed

the nation[60] and contains information related to over three million Texas cancer patients diagnosed since 1995. Information about patients seeking treatment for cancer in Texas may be captured in the state, but the Registry will report the information to the patient's home state.

Texas funds the cancer registry with both general revenue and federal funding through the CDC's National Program of Cancer Registries (NPCR). The program is also credentialed and participates in the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute (NCI), and receives additional funding from SEER. It is one of 12 state registries funded by both the SEER Program and the CDC's NPCR.

The state's registry contains comprehensive cancer data from 1995 through 2021 and supports surveillance of cancer, evaluation of disease trends and health management, and "measures progress in prevention, diagnosis, treatment, and survivorship" of cancer across Texas. It affords a wide variety of cancer-related research to inform prevention strategies and treatment.

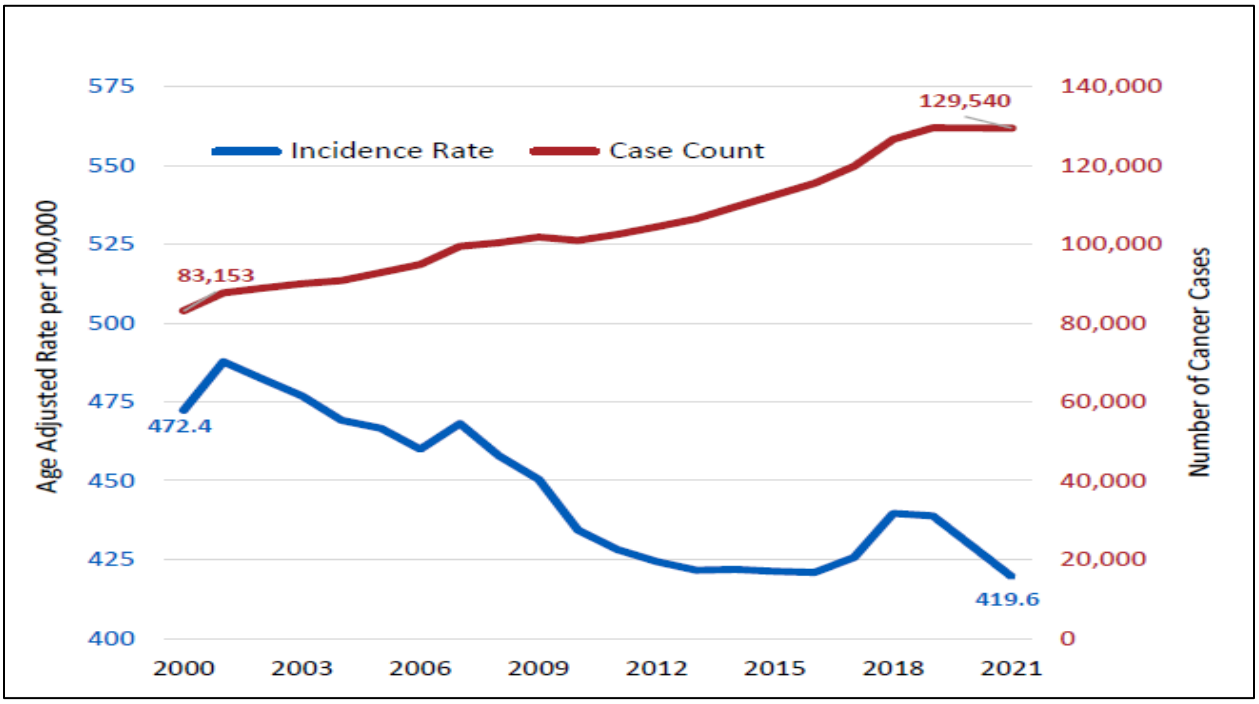
Trends in Cancer

Cancer is a leading cause of death for Texans age 35 and under.[61] While overall incidence rates have decreased, the total number of new cases of cancer continues to increase, owing largely to a population that is both growing in size and aging. From 2012 to 2021, the age-adjusted cancer death rate in Texas dropped by nearly 1.7 percent per year over the past decade; however, cancer remains the second largest cause of death overall in Texas behind heart disease.[62]

The most diagnosed cancers in Texas are: breast, prostate, lung, and colon. The most significant sources of cancer deaths in Texas are: lung, colon, breast, pancreatic, and liver.

[60] Manda Hall, M.D., Texas Department of State Health Services, *Testimony before the Texas Senate Committee on Health and Human Services*, May 14, 2024.
[61] Kristen Doyle, Cancer Prevention and Research Institute of Texas, *Testimony before the Texas Senate Committee on Health and Human Services,* May 14, 2024.
[62] Manda Hall, M.D., Texas Department of State Health Services, *Testimony before the Texas Senate Committee on Health and Human Services*, May 14, 2024.

Figure 12: Trends in Total Number of Invasive Cancer Cases and Incidence Rates, Texas, 2000-2021



Source: *Texas Cancer Registry, Department of State Health Services*

- For women in both the U.S. and Texas, **breast cancer is the most commonly diagnosed cancer**. In Texas women, an estimated 20,319 cases of breast cancer are expected to be diagnosed in 2023, followed by lung cancer (7,267 cases) and cancer of the uterus (4,366 cases). Cancers of the colon and thyroid are expected to be the fourth and fifth leading cancers in women in 2023.

- For men in both the U.S. and Texas, **prostate cancer is the most commonly diagnosed cancer.** In Texas men, an estimated 17,584 cases of prostate cancer are expected to be diagnosed in 2023, followed by lung cancer (8,479 cases) and colon cancer (4,644 cases). Kidney and renal pelvis and urinary bladder cancer are expected to be the fourth and fifth leading cancers in men in 2023.

Table 7: Top Ten Cancers in Texas for Women

Rank	Cancer	Age-Adjusted Rates (per 100,000)		Annual Percent Change*	Trend
		2012	2021		
1	Breast	115.5	124.2	+1.1*	Rising
2	Lung	46.2	37.4	-1.8*	Falling
3	Colorectal	32.4	32.2	+0.1	Stable
4	Uterine (endometrial)	20.3	26.3	+2.7*	Rising
5	Thyroid	19.1	15.9	-2.0*	Falling
6	Kidney & Renal Pelvis	13.6	14.2	+0.9*	Rising
7	Non-Hodgkin Lymphoma	15.7	13.8	-0.8	Non-sig. decrease
8	Melanoma of the skin	9.5	11.8	+3.3*	Rising
9	Pancreas	10.8	11.6	+1.2*	Rising
10	Leukemia	11.5	11.6	+0.3	Stable

*Statistically significant change

Source: *Texas Cancer Registry, Department of State Health Services: https://www.dshs.texas.gov/tcr*

Table 8: Top Ten Cancers in Texas for Men

Rank	Cancer	Age-Adjusted Rates (per 100,000)		Annual Percent Change*	Trend
		2012	2021		
1	Prostate	101.2	105.6	+1.9%	Non-sig. increase
2	Lung	69.3	47.9	-3.5%*	Falling
3	Colorectal	47.1	44.5	-0.3%	Stable
4	Kidney & Renal Pelvis	25.6	26.9	+1.2%*	Rising
5	Bladder	28.2	26.9	-0.8%	Non-sig. decrease
6	Non-Hodgkin Lymphoma	22.2	20.7	-0.4%	Stable
7	Melanoma of the Skin	16.5	21.0	+2.9%*	Rising
8	Liver	16.9	18.9	+1.4%*	Rising
9	Oral Cavity & Pharynx	16.3	18.1	+1.0%*	Rising
10	Leukemia	19.0	17.8	-0.7%*	Falling

*Statistically significant change

Source*: Texas Cancer Registry, Department of State Health Services: https://www.dshs.texas.gov/tcr*

Texas also is experiencing an increasing trend of early onset cancer in several common forms. *"Early Onset"* is classified as adults younger than 50 years being diagnosed with a form of cancer. The most common diagnoses for this group include the following types: breast, colorectal, uterine,

and cervical.[63] The incident rates in these types of cancers are increasing in younger adults likely due to in part to changes in modifiable lifestyle risk factors and increase use of screening tests.

Researchers are evaluating the causes of earlier onset cancers within Texas, as well as nationally. Dr. Ernest Hawk, M.D., the University of Texas MD Anderson Cancer Center, noted that current hypotheses for these causes include rising rates of obesity among children/youth, changes in diets from sugar-sweetened beverages, ultra-processed foods, microplastics, or changes in the intestinal microbiome.

Table 9: Annual Percent Change (APC) by Age Group, 2012–2021, Texas

Type	Age Group	APC (percent)	Trend
Breast	20-50	+1.1	Rising
Colorectal Cancer	20-34	+3.4*	Rising
	35-49	+2.0*	Rising
	50-64	+0.9	Non-sig. increase
	65-79	-1	Non-sig. decrease
	80+	-1.2	Non-sig. decrease
Uterine Cancer	20-34	+3.1	Non-sig. increase
	35-49	+3.3*	Rising
	50-64	+2.4*	Rising
	65-79	+3.0*	Rising
	80+	+1.6	Non-sig. increase
Cervical Cancer	20-24	-13.3*	Falling
	25-29	-4.2	Non-sig. decrease
	30-39	-2.2	Non-sig. increase
	40-49	+1.9*	Rising
	50+	+0.8	Non-sig. increase

***Source**: Texas Cancer Registry, Department of State Health Services: https://www.dshs.texas.gov/tcr*

Cancer and COVID-19 Public Health Emergency

The increasing rates of cancer incidence and early onset cancer diagnoses preliminary research presented by Dr. David Wiseman and the Covid-era Cancer Uptick Study Group (CCUSG) suggested the role of SARS-Cov-2 and COVID-19 vaccines should be studied as part of a cancer prevention strategy.

[63] *Ibid.*

"Covid-19 vaccines were not tested for cancer effects, which you would expect in a new pharmaceutical," Wiseman stated. Proportional reporting ratio (PRR) analyses conducted by the Centers for Disease Control and Prevention in 2022, which were requested under a freedom of information request, revealed some cancer types for which there are "safety signals" from the mRNA covid vaccines.[64] Wiseman noted that "a signal does not indicate causality, it means 'check your engine.'"

While these data suggest there could be connections between COVID-19 infections or vaccination and cancer diagnoses, Texas currently does not collect the incidence of infection or vaccination in relation to reported cancer cases, according to the Department of State Health Services (DSHS).

In 2022 and 2023 DSHS reported that the Texas Cancer Registry (TCR) requested that hospital facilities report four COVID-19 related data items (whether a COVID-19 test had been taken, the date of the COVID-19 test, whether the COVID-19 test was positive, and whether the COVID-19 diagnosis impacted cancer treatment) to determine if there is any impact from COVID-19 on individuals with cancer. But this data collection was limited to patients already diagnosed with cancer in order to study the effects of the pandemic on treatment and survival.

DSHS cautioned that the information collected was not intended to (and cannot be used to) examine risk factors for cancer due to COVID-19 exposure or vaccination.

Cancer Treatment, Screening, Detection and Prevention

Witnesses testified that between 30 percent and 50 percent of all cancer cases are preventable.[65] Measures such as vaccinations, screenings, survivorship resources, and tools for quitting tobacco and alcohol remain the most cost-effective means for controlling cancer.[66]

There is new promise in tools that use "molecularly driven strategies" for detecting cancers that are not yet identifiable through available screening methods. In testimony, Dr. Ernest Hawk of The University of Texas MD Anderson Cancer Center noted that multi-targeted fecal assay (known as Cologuard) for colorectal cancer "identifies individuals with advanced adenomas or colorectal cancers with around 80 percent to 95 percent sensitivity, rivaling colonoscopy's sensitivity."

Additionally, researchers are developing blood-based 'assays' for colorectal cancer (CRC) and to identify a host of other cancers across organs. "While able to detect advanced cancers reliably, the test's sensitivity for advanced adenomas or early stage CRC is limited," Hawk noted. And while

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[64] Letter from U.S. Senator Ron Johnson to Dr. Rochelle Walensky, Director, Centers for Disease Control and Prevention, June 23, 2022. https://www.ronjohnson.senate.gov/services/files/AB68101B-CDA4-49F1-8174-4274DDEB0120; Zachary Stieber, "Exclusive: CDC Finds Hundreds of Safety Signals for Pfizer and Moderna COVID-19
Vaccines," *Epoch Times*, January 3, 2023.
https://www.theepochtimes.com/health/exclusive-cdc-finds-hundreds-ofsafety-signals-for-pfizer-and-moderna-covid-19-vaccines_4956733.html

[65] Ernest Hawk, M.D., The University of Texas MD Anderson Cancer Center, *Testimony before the Texas Senate Committee on Health and Human Services,* May 14, 2024.

[66] Kristen Doyle, Cancer Prevention and Research Institute of Texas, *Testimony before the Texas Senate Committee on Health and Human Services*, May 14, 2024.

medical and pharmaceutical firms are investing in the development of blood-based cancer detection tests, termed multi-cancer early detection tests or MCEDs, none have been proven to yet reduce cancer mortality or advance the stage of cancer detection, he noted.

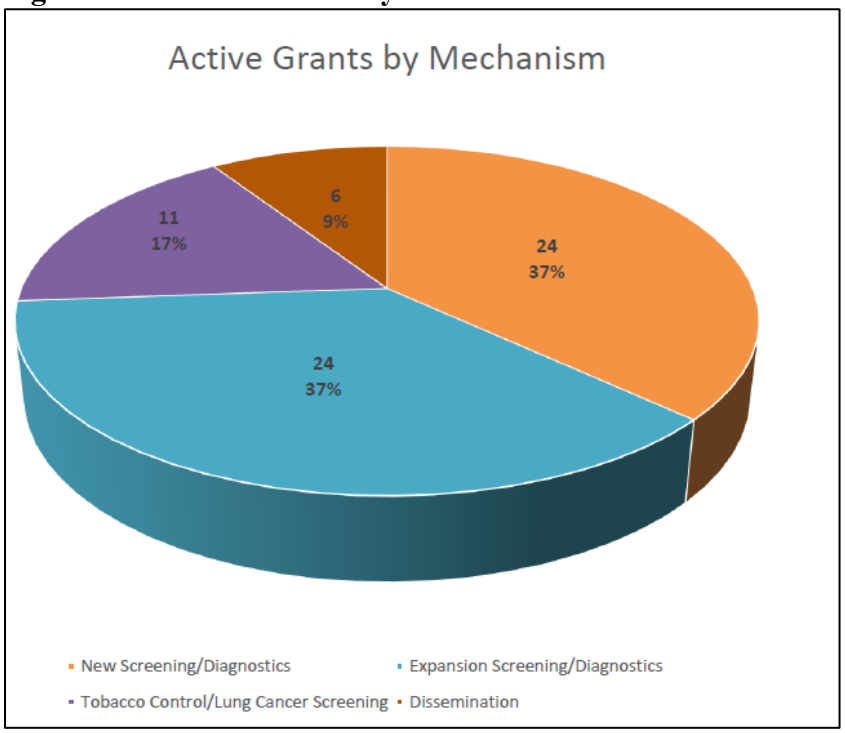
The U.S. Food and Drug Administration has not approved any of these MCEDs for patient application.[67]

Under state law, up to 10 percent of CPRIT's budget may provide funding for prevention efforts. These programs fund a variety of evidence-based prevention services throughout Texas, with many grants concentrated on medically underserved communities in order to increase access to care.

"At least one CPRIT prevention project is available in every Texas county," Kristen Doyle, deputy executive officer and general counsel of CPRIT, reported to the committee.

Since 2010, CPRIT has granted the maximum amount of funding in prevention initiatives, resulting in $381 million in grants to support 303 prevention projects throughout the state. The majority of these initiatives are split among educational and clinical efforts, including early screening services for breast, colon, cervical and lung cancers and educational and cessation programs to help decrease behaviors that lead to cancer risk. CPRIT is also funding the development of early detection tools for screening cancer and research efforts to identify the early factors that lead to cancer.

Figure 13: CPRIT Grants by Prevention Mechanism



Source: *CPRIT Prevention Advisory Committee*

[67] U.S. Department of Health and Human Services, National Institutes of Health, "Questions and Answers about MCD Tests," *NIH: About Cancer Screening Website*, *Accessed November 27, 2024*. https://prevention.cancer.gov/major-programs/multi-cancer-detection-mcd-research/questions-and-answers-about-mcd-tests

Despite these advances, the use of screening and prevention tools is hindered by the same general barriers to healthcare services, including limited availability of physicians, specialists and facilities to perform these services, as well as payor sources to cover all these resources.

CPRIT's prevention programs are a major source of providing affordable access to cancer screening and treatment. The agency has funded more than $9.6 million prevention services, which include:

- **Providing grants for Tobacco Cessation and Lung Screening:**
  Lung Cancer Screening and Patient Navigation (LSPAN) program operating in North Texas. CPRIT Award PP180025: $1,499,997 (March 2018–August 2023).

- **Equitable Access to Lung Cancer Screening and Smoking Cessation Treatment: A Comprehensive Primary Care and Community Health Approach partnership** with Harris Health and Baylor College of Medicine to deliver lung cancer screening and smoking cessation treatments in Houston. The program served as a pilot for the system that approved the lung cancer screening as a service on the schedule of benefits. 27 percent of the 14 thousand participants stopped smoking. CPRIT Award PP180016: $1,472,918 (February 2018–February 2021).

- **Texas Cancer Screening, Training, Education and Prevention Program (C-STEP)** project. Funded by CPRIT since 2018, the C-STEP project provides life-saving cancer screenings and advanced diagnostics through the Texas A&M University family medicine residency training program. C-STEP has dramatically expanded the availability of various cancer screenings for safety-net patients and increased the number of family medicine physicians trained to conduct colonoscopy screenings.

- **Vaccinating Medically Underserved Women against HPV**
  UTMB clinics funded for Patient Navigators (PNs) to counsel female patients about HPV vaccine. Only 18 percent of the women seen at UTMB clinics in Galveston County or Hidalgo County had been receiving HPV vaccine. Many of these patients belonged to at-risk populations for developing HPV-related cancers**.** UTMB clinics participating in the project served residents of eight counties (four medically underserved areas (MUA); three MUA/Rural).
  CPRIT Award PP180012: $1,344,926 (August 2018 –August 2022).

- **Colorectal Cancer Screening in Vulnerable Populations -Travis County**
  In partnership with UT Austin Dell Medical School using a CPRIT grant, the program gave CRC screening to unscreened, eligible patients at CommUnityCare (CUC), the largest FQHC in Travis County. CPRIT Award PP170082: $2,292,964 (August 2017–February 2022).

Conclusion and Recommendations

Invited witnesses provided information to the Senate panel concerning how Texas has invested in cancer research, how research is currently supporting community initiatives to increase access to cancer screening and treatment, and how state investments could be leveraged to reduce the overall incidence of cancer diagnoses among state residents. Policymakers should continue current CPRIT prevention services and maintain the current structure of funding for investments in medical devices and tests to support earlier cancer detection.

Members of the Senate committee also asked about the need for additional public awareness on the connections between diet, environmental factors and cancer incidence. Witnesses suggested that DSHS could implement additional data points for collection in its cancer registry for incidence rates for early-onset cancers with an emphasis on diet profile, lifestyle, alcohol use, and environmental exposures, including the impacts of COVID-19.

INTERIM CHARGE V: MONITORING

The Senate Health and Human Services Committee was directed to monitor the status of agencies and programs overseeing the implementation of relevant legislation passed by the 88th Legislature. Several legislative measures were included with summarized updates of their progress featured below.

S.B. 7 (88-3)

Relating to prohibiting a private employer from adopting or enforcing certain COVID-19 vaccine mandates; authorizing an administrative penalty.

- ***Summary***
    - While the legislature passed Senate Bill 29 during the 88th Legislature, Regular Session, to prevent governmental entities from requiring individuals to receive a COVID-19 vaccination, there was no such explicit protection in law for employees of private employers.
    - Senate Bill 7 sought to better protect individuals' right to make their own medical decisions by prohibiting private employers from mandating that their employees or contractors receive the COVID-19 vaccine.
    - The bill required the Texas Workforce Commission (TWC) to establish a system for accepting complaints on vaccine mandates, investigate actionable complaints, and assess the mandatory employer administrative penalty if substantiated.
    - TWC is also responsible for conducting hearings related to employers appealing the assessment of the administrative penalty.
    - S.B. 7 required TWC to adopt rules to implement and enforce the provisions of the bill. The rules will provide detail on the process for accepting, and investigating complaints, clarifying the definitions in the bill, and the commission's jurisdiction over employers, particularly those with operations outside of Texas.
- ***Implementation Status***
    - TWC determined it could begin accepting complaints regarding violations of the COVID-19 vaccine mandate prohibition starting February 2024. However, the commission has been holding these complaints in abeyance until the rules to fully implement S.B. 7 are adopted and take effect.
    - To facilitate the process, TWC created an "S.B. 7 information page" on its public website, along with an accessible, automated complaint form from this page. Both the information page and the complaint portal were established within five days of the bill's effective date. Complainants must attest the following:
        - The complainant experienced an adverse action under their employer's COVID-19 vaccination mandate policy;

        - This action occurred after February 6, 2024; and
        - The complaint is filed in good faith.
    - Proposed rules were initially presented to the three TWC commissioners at a public meeting on July 9, 2024. However, the commissioners recommended revisions to the proposed rules that necessitated a re-drafting. TWC staff will re-present these rules at a public meeting in mid-September. If adopted in November, the rules would take effect in December 2024.

S.B. 24 (88R)

Relating to the powers and duties of the Health and Human Services Commission and the transfer to the commission of certain powers and duties from the Department of Family and Protective Services.

- ***Summary***
  - Senate Bill 24, the Thriving Texas Families Act, amended the Texas Family Code and the Texas Human Resources Code to consolidate support programs, including the Prevention and Early Intervention division at the Department of Family and Protective Services (DFPS), to the Family Support Services division within th Health and Human Services Commission (HHSC) under Texas Government Code.
  - Additionally, the bill codified the "Texas Pregnancy and Parenting Support Network" (formerly, the Alternatives to Abortion program) in order to fund services to families to promote healthy pregnancy, childbirth, and family formation; and help families achieve economic self sufficiency. The bill directs HHSC to continue to contract for services to women who are pregnant or who have young children, under the age of 36 months, in order to ensure coordinated support for the following:
    - Information and services for prenatal health and childbirth;
    - Access to acute care services;
    - Counseling and mentoring services for pregnancy, education, parenting skills, adoption services, life skills, and employment readiness;
    - Coordination with other programs to help families secure child care, transportation, housing, and state and federal benefits;
    - Access to infant care supplies and materials; and
    - Access to housing through maternity homes.
  - The bill made changes in the establishment of the Texas Pregnancy and Parenting Support Network to ensure it is implemented as a continuation of the current Alternatives to Abortion program and not an entirely new program. This change ensured continuity in the program for current services and providers.
  - The bill added clarification to the definition of "network contractor" to make clear that definition includes current contractors in the current Texas Alternatives to Abortion program.
  - S.B. 24 also made a technical change to strike language that requires HHSC to use a "statewide network of providers" and replaces it with the definition of "network contractors" under Section 54.001 of the bill.

- S.B. 24 amended current law relating to the powers and duties of HHSC and the transfer to the commission of certain powers and duties from DFPS.
- Finally, the bill removed the requirement for the program to seek federal funding by striking the words "federal" and "government."

- ***Implementation Status***
  - Transition efforts began August 16, 2023, with coordinated efforts between DFPS and HHSC to project governance structure and management approach. In advance of a September 1, 2024, transition deadline, DFPS and HHSC staff participated in functional workgroups to define and assign necessary tasks. Furthermore, to assist Family Support Services grantees during the transition, HHSC staff assisted in the request for application (RFA) evaluation process for new funding initiatives, participated in a panel with DFPS for the Partners in Prevention grantee day, and conducted local site visits to grantees.
  - HHSC worked with Thriving Texas Families grantees to develop a framework for measuring program outcomes, including program goals, outcomes, and associated impact metrics, as required by S.B. 24. HHSC developed a new program database to support the framework. Both the outcomes framework and database are effective September 2024.
  - On November 8, 2023, HHSC released a request for applications for Thriving Texas Families pilot projects.
  - HHSC scheduled to post a request for proposals (RFP) solicitation in September 2024 for an external third party evaluator, as S.B. 24 requires measuring the effects of services on program participants and reporting on measured performance outcomes.
  - The Thriving Texas Families core program and pilot projects are set to expire August 31, 2025. HHSC expects to post a new RFA to solicit a network of Thriving Texas Families service providers in compliance with the Texas Health and Safety Code Chapter 54. A pre-solicitation notice is available now on the HHSC Procurement Forecast webpage.

S.B. 25 (88R)

Relating to support for nursing-related postsecondary education, including scholarships to nursing students, loan repayment assistance to nurses and nursing faculty, and grants to nursing education programs.

- ***Summary***
    - The Nurse Faculty Loan Repayment Program (NFLRP) and the Nursing Innovation Grant Program (NIGP) are two key programs that were created to help address this shortage. The NFLRP improves access to nursing education programs by encouraging qualified nurses to serve as faculty at eligible Texas institutions of higher education through loan repayment assistance. The NIGP was established to provide grants to higher education institutions to promote the education, recruitment, and retention of nursing students and qualified faculty. Senate Bill 25 is part of a comprehensive package to dramatically increase funding and resources to nursing education and training programs, including those addressed in S.B. 25. The key provisions of S.B. 25 include the following:
    - Nurse Faculty Loan Repayment Program (NFLRP): S.B. 25 amended the Education Code to allow part-time nursing faculty to be eligible for loan repayment assistance. It also removes the repayment from a cap of $7,000 annually to an amount to be determined by the Texas Higher Education Coordinating Board (THECB).
    - The Nursing Students Scholarship Program and Nurse Loan Repayment Program were created through amendments to Education Code Chapter 61, Subchapter L. The Nursing Students Scholarship Program promotes health care and educational needs by providing scholarships to eligible professional and vocational nursing students at Texas public and independent institutions of higher education. The Nurse Loan Repayment Program provides up to $16,000 in educational loan repayment assistance (varying by type of nursing license) to nurses working in Texas for at least one year.
- ***Implementation Status***
    - THECB was called to testify during the committee's May 14th hearing. According to testimony, the amendments and funding did not make it possible for implementation prior to the 2024–2025 academic year.
    - Witnesses explained that negotiating rules to govern the Nursing Students Scholarship Program were necessary, as funding would be going to institutions for their discretionary use.
    - While the rules that govern the newly created Nurse Loan Repayment Program did not require negotiated rulemaking, THECB received stakeholder feedback and both sets of rules were approved in July 2024, with effective date in August. The witnesses also mentioned that the technology associated with both programs should be functional by launch in September.

- Finally, the witnesses said that THECB will be pushing the availability of these programs to applicable institutions as soon as possible.
- Notably, while in the negotiated rulemaking process for the Nursing Students Scholarship Program, the initial draft of rules limited the program to undergraduate nursing students, despite Senate Bill 25 allowing for post-graduate students to be eligible. In response to comments submitted by the Texas Nurses Association during the public comment period, the Board revised the final rule to make both undergraduate and graduate nursing students eligible for the program.

S.B. 26 (88R)

Relating to local mental health authority and local behavioral health authority audits and mental and behavioral health reporting, services, and programs.

- ***Summary***
  - Despite historic investments in mental health, issues continue as more individuals with serious mental illness present with substance use issues, cycling in and out of hospitals, community programs and jail.

  - Senate Bill 26 sought to expand mental health capacity, especially for children and adolescents, through the creation of an innovation grant program to fund services design to mitigate the need for future intensive and facility-based care and the number of children at risk of placement in foster care or the juvenile justice system.

  - The bill also directed a structured methodology for discharging state hospital patients with multiple admissions and discharges within a 30-day period or who experienced a stay longer than 365 days.

  - S.B. 26 requires inpatient mental health facilities to only approve the admission of a person for whom a proper request for voluntary inpatient mental health services is filed, if at the time of the request, there is available space at the facility.

  - The bill increased transparency and accountability for the Texas community-based mental and behavioral health systems by requiring them to submit to regular performance audits conducted by the Office of Inspector General (OIG) and to increase data reporting to HHSC related to the populations they serve to better assess needs in communities. New data elements include:
    - Timely and adequate screening of clients;
    - Timely access to community-based crisis services;
    - Improved functioning as a result of medication related services;
    - Length of time between referrals and admissions;
    - Rates of denial of service requests from jails and other entities;
    - Quality of care; and
    - Number of hours of services provided.

  - OIG must conduct a performance audit of each authority at least once every five years and collect a financial audit on every authority every three years. OIG may request additional audits if necessary.

  - Finally, S.B. 26 directed the development of incentives to support long-term placement for elderly Texans with intense behavioral health needs. The bill amended current law relating to local mental health authority and local behavioral health authority audits and mental and behavioral health reporting, services, and programs.

- ***Implementation Status***
    - Innovation Grants: HHSC released the Request for Application (RFA) for the grant on January 10, 2024. HHSC received 48 applications and selected 20 grantees. Contracts are currently being routed for selected applicants and services funded under the grants will operate from July 1, 2024, through August 31, 2025.
    - HHSC has completed the hiring for discharge planning specialists. The state hospital discharge specialists have facilitated 65 discharges as of July 2024, and at least six of those had a hospital length of stay ranging from approximately 10 15 years at discharge.
    - The voluntary admission policy for state hospital s has been implemented. Thus far, there have been 19 referrals for community placements due to lack of capacity.
    - HHSC is in the process of implementing the data reporting requirements for local mental and behavioral health authorities (LMHAs). All data points and measures will be captured and reported by September 2025.
    - Additionally, OIG began the process to implement the audit requirements of the bill. It completed the first four audits of the following LMHAs:
        - Bluebonnet Trails
        - Betty Hardwicke
        - Texana
        - MHMR Concho Valley
- OIG will continue audits rotating among the 39 local mental and behavioral health authorities with audits each biennium.

S.B. 1849 (88R)

Relating to an interagency reportable conduct search engine, standards for a person's removal from the employee misconduct registry and eligibility for certification as certain Texas Juvenile Justice Department officers and employees, and the use of certain information by certain state agencies to conduct background checks.

- ***Summary***
  - Senate Bill 1849 sought to reduce the risk of harm to vulnerable populations in schools, child-care and juvenile justice facilities, and long-term care facilities by creating a search engine connecting the databases of reportable conduct at the Texas Education Agency (TEA), the Texas Juvenile Justice Department (TJJD), the Health and Human Services Commission (HHSC), and the Department of Family and Protective Services' (DFPS) Central Registry of abuse and neglect findings to ensure that workers who committed reportable conduct cannot gain employment in another setting. The Texas Department of Information Resources (DIR) will provide technology tools and platforms to create the search engine.
  - This bill and the search engine only cover the populations currently eligible in the TEA, HHSC, TJJD, and DFPS registries. The bill did not expand the individuals that would be placed on the registries. It does not, for example, include "contractors" in schools or Law Enforcement or First Responders.
  - S.B. 1849 also required licensed providers that serve vulnerable populations (children and adults) to conduct a search of these registries when they are hiring applicants seeking employment in these facilities.
  - Providers required to access the search engine (once operational) are:
    - Public schools, charter schools, and education services centers;
    - Non-profits providing educational tutoring services in connection with schools;
    - Licensed or certified long-term care providers;
    - Nursing homes;
    - Assisted living facilities;
    - Home and community support services agencies;
    - Day activity and health services providers;
    - Intermediate care facilities for IDD patients;
    - Prescribed pediatric extended care centers (PPEC);
    - State supported living centers;
    - Providers of 1915 (c) Waivers – HCS waivers; and

- Juvenile justice facilities and probation departments.

- Childcare providers (including both daycare and residential childcare facilities) will continue to check HHSC's Centralized Background Check Unit (CBCU) for applicants, but the CBCU will have access to SEMARC, so these providers will have access to the TEA and JJ probation registries.

- S.B. 1849 directed agencies to adopt rules outlining bars to employment considerations and requirements and due process for TJJD-related applicants. The search will identify potential red flags and the agency will adopt rules for how licensed entities may hire or proceed based on the level of risk. This will not automatically result in an applicant being denied a job.

- HHSC and TEA have rules today that result in licensed entities or schools hiring a person on their respective lists.

- Entries into the DFPS Central Registry are individuals "suspected" or confirmed to have abused or neglected a child or adult.

    - Parents listed in the Central Registry in a CPS investigation are not flagged for purposes under S.B. 1849. ONLY individuals listed in the Central Registry who have been employed in residential childcare settings will be searched under the Texas Interagency Reportable Conduct Search Engine.

- There are more than 780,000 perpetrators listed in the Central Registry but only 10,509 are related to CHILDCARE and would be subject to the search engine.

- S.B. 1849 will require that employers of the provider categories be able to access the full name, and at least of the following data points:

    - the individual's date of birth;

    - the last four digits of the individual's social security number;

    - a description of any reportable conduct in which the individual engaged; and

    - the date on which the reportable conduct occurred.

- An individual who engaged in reportable conduct that requires the individual's inclusion in the database is not entitled to notice or an opportunity for a hearing before the individual's information is included in the database. But if the person's name comes up in a search, they will be notified and offered due process.

- Agencies are required to promulgate rules for access and search frequency under the bill.

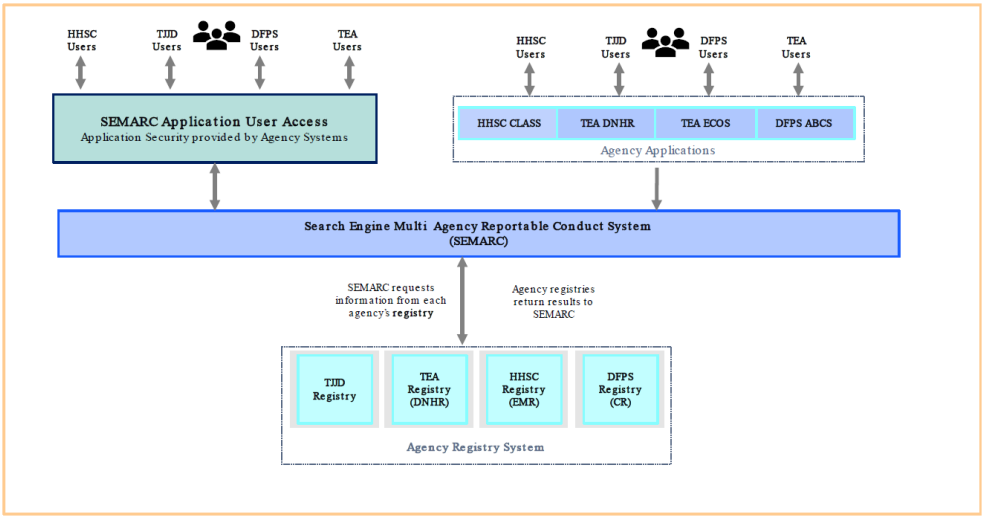
- Bill Funding:
    - A contingency rider in H.B. 1 (88R) provided $8M to create a work plan to build the search engine. The work plan is being developed currently with Deloitte and once complete, will contain full costs for creating the search engine.

- ***Implementation Status***
    - Since S.B. 1849 became effective in 2023, the organizing agencies have officials named the system Search Engine for Multiagency Reportable Conduct (SEMARC).
    - DFPS is the lead agency for SEMARC. It implemented the bill's required internal Office of Interagency Coordination on Reportable Conduct (OICRC). A director was hired in July 2024. OICRC responsibilities include:
        - Coordinate the development of processes for data sharing, exchange of records, security, and ongoing system management.
        - Serve as a central point of contact for coordination of responses to inquiries regarding the bill's implementation.
    - S.B. 1849 requires the participating state agencies to enter a memorandum of understanding (MOU). Areas under MOU include:
        - Data Exchange: Information sharing between agencies.
        - Governance: Collaboration and decision structure between agencies.
        - OICRC Role: DFPS as system coordinator and lead contact.
        - Ongoing System Management: system change requests, system maintenance, Help Desk support.
    - HHSC has initiated the rulemakings necessary to implement S.B. 1849 but will require budget resources to build the Application Programming Interface (API) and automate functions to facilitate new background checks under the Childcare Licensing Automation Support System (CLASS) for SEMARC to effectively operate.
    - TEA is in the process of reviewing all its operations to ensure compliance with SEMARC and entering into MOUs with other agencies. Once complete, TEA will initiate rule.
    - TJJD is creating a new database to serve as its registry and will contain certified county probation officers whose certifications have been revoked by the TJJD board and TJJD employees who have been deemed ineligible for certification by the TJJD board.
    - TJJD is crafting rules and policies to determine how information from the other participating agencies will be used to make employment, certification, contracting,

and volunteer decisions for TJJD and for juvenile probation departments and local facilities.

- DIR is collaborating TEA, HHSC, DFPS, and TJJD to identify and develop components for successfully integrating SEMARC with existing applications. DIR will provide support and assistance for determining policies related to:
  - User authentication and authorization aligns to agency system access, including the impact to workflow and employees at agencies and training and communications strategy; and
  - Policy and process alignment through business assessments.

Figure 14: Department Information Resources SEMARC Architecture



Source: *Texas Department of Information Resources*

- ***Recommendations***
  - Consider increasing appropriations to implement the remaining sections of S.B. 1849 and ensure that SEMARC functions as intended and allows searches for individuals with reportable conduct for all populations covered under the bill.

  - Consider expanding jurisdiction of current registries to include "contracted" staff with the participating agencies/entities so that these individuals would be searchable in SEMARC.

INTERIM CHARGE V: MONITORING: MEDICAID FRAUD

***Monitoring**: Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services passed by the 88th Legislature, as well as relevant agencies and programs under the committee's jurisdiction. Specifically, make recommendations for any legislation needed to improve, enhance, or complete implementation of the following:*

- *Initiatives to reduce Medicaid fraud, waste, and abuse, as well as other cost containment strategies and Medicaid managed care oversight and accountability.*

Introduction

As the oversight committee for human services programs in Texas, the Senate Committee on Health and Human Services convened an interim hearing on September 18, 2024, to monitor the initiatives that the Texas Health and Human Services Commission (HHSC), the Office of the Texas Attorney General (OAG) and the Office of the Inspector General (OIG) are undertaking to reduce fraud, waste, and abuse of the state's Medicaid program. As part of this charge, the committee invited subject matter experts from all three of those agencies along with the chief executive officer of the Texas Association of Health Plans, which represents the major health insurance companies that contract to provide managed care services in Texas Medicaid.

The committee members sought to understand how these agencies are ensuring the integrity of the Medicaid system and how insurance industry partners are delivering necessary services while reducing fraud and abuse opportunities so that Medicaid remains viable for all eligible Texans who rely on it for their health and well-being.

Background

Medicaid is a jointly funded state-federal program for low-income individuals, while the Children's Health Insurance Program (CHIP) serves children whose parents earn too much to qualify for Medicaid but cannot obtain private insurance.

Medicaid covers approximately 4.3 million Texans, representing about 14.6 percent of the state's population. Notably, Medicaid also covers over 50 percent of Texas births, and 43 percent of Texas children are enrolled in Medicaid or CHIP. Furthermore, Medicaid supports 56 percent of residents in nursing homes, highlighting its extensive reach across our state.

Medicaid is the single largest program funded in the state budget, essential for millions who rely on it for life-saving treatment. However, it is also a key driver of state and federal spending. As legislators, we know that where there is significant funding, there can be waste, abuse, and outright fraud. In July 2024 alone, Texas reported over $33.4 million in fraud investigations, with the most recent quarter exceeding $100 million.

Currently, Texas Medicaid services are largely delivered through a "managed care" model, much like private health covers. Under this model, Texas Medicaid pays contracted insurance plan or

managed care providers a "per member, per month" rate to manage recipient care and prevent needless medical encounters such as emergency room visits more efficiently. Approximately 97 percent of Medicaid recipients are served through managed care organizations, while the remaining three percent receive services through a fee-for-service model.

Eligibility for Medicaid is determined by federal law, which mandates coverage for specific groups of people such as pregnant women, the disabled and the elderly. However, states are permitted to provide coverage to additional populations. Eligibility is assessed based on both financial criteria, such as income levels, and non-financial criteria, including age, residency, and citizenship status.

The governing framework for Medicaid services is established by the federal Centers for Medicare and Medicaid Services (CMS), which provides guidelines based on the Social Security Act. HHSC is the single state agency responsible for operating the state Medicaid program, managing Texas' state plan, which is a joint contract with the federal government outlining covered services, eligibility for populations that can receive Medicaid, requirements to serve as providers in the program, and how rates are established for covered services.

The Texas state plan covers various services, including acute care (e.g., doctor visits, hospital services, pharmacy), long-term services and supports, behavioral health services, medical transportation, and pharmacy services. It also provides additional services, including:

- Early and periodic screening, diagnosis, and treatment (EPSDT) for children under 21, which ensures access to medically necessary services not explicitly covered in our state plan.
- Value-added services offered by managed care organizations (MCOs), which may include health-related services like gym memberships and dental care for pregnant women.

In-lieu-of services, which MCOs can choose to provide based on evaluations, and case-by-case services that MCOs can offer based on medical necessity and cost-effectiveness.

Following the COVID-19 pandemic, states have been directed by the federal government to disenroll individuals from Medicaid who are no longer eligible. At the pandemic's peak, Texas covered more than six million individuals—nearly double the typical Medicaid population. Numerous studies have indicated that fraud rates during this period have significantly increased. For instance, a report by the federal Office of Inspector General at the U.S. Department of Health and Human Services found that Texas MCOs received payments for individuals listed on Medicaid in Texas and other states.

The system can be vulnerable to abuse, making it enticing for certain providers to exploit government programs for services that may not be covered or to overstate the value of delivered services. Recently, there have been allegations that a children's hospital has been billing Medicaid for illegal transgender surgeries and treatments. While this matter is still under investigation, it raises significant concerns and is at the forefront of our discussions, especially since we have enacted laws to protect minors.

Summary of the Testimony

Texas Medicaid undertakes several initiatives to ensure the integrity and transparency of the Medicaid program and that it follows federal law and administrative rules established by CMS.

Emily Zalkovsky, chief Medicaid and CHIP services officer at HHSC, explained how the agency integrates fraud prevention measures into its programs by undertaking certain activities, such as conducting audits and utilization reviews and imposing quantity limits for certain services.

HHSC consults with the Office of the Inspector General to identify potential fraud risks when exploring adding a new service to the Medicaid state plan.

The agency also relies on contractual requirements for MCOs to monitor and investigate fraud, waste, and abuse. The HHSC Uniform Managed Care Manual requires each MCO to have a Special Investigation Unit (SIU) to detect and investigate fraud and submit a monthly report to OIG outlining all SIU activities and the status of each investigation.

MCOs use large data systems to help catch patterns with claims and providers like physicians or durable medical providers. They can hold payments until the questionable activity is resolved.

Jamie Dudensing, chief executive officer of the Texas Associations of Health Plans (TAHP), which represents major health insurance managed care organizations, testified on what activities are considered "fraud, waste or abuse." Fraud involves intentional deception or misrepresentation, such as upcoding or billing schemes, she noted. Abuse refers to providing care that is not evidence-based, and waste typically relates to unnecessary costs that could be avoided through prior authorizations or care management, such as preventing unnecessary ER visits, she added.

Fraud Schemes and Recoveries

Fraud schemes that OAG and OIG investigate and prosecute include:

- Billing for services that were never provided under Medicaid;
- Paying individuals to enroll as Medicaid recipients to bill for unnecessary services or for services never rendered;
- Offering, paying, soliciting, or receiving remuneration to induce referrals or services covered by Medicaid;
- Fraudulent prescribing or distribution of prescription medications (opioids) for non-medical use;
- Using someone else's Medicaid information to submit fraudulent claims; and
- Unbundling or upcoding services provided, to illegally maximize costs.

The Texas Fraud Prevention Partnership

(OIG) and OAG work in concert with HHSC and MCOs to address administrative, civil, and criminal fraud, waste, and abuse violations within Texas Medicaid.

The OIG addresses administrative violations, while the OAG addresses the issues from two distinct divisions under the authority of the Texas Healthcare Fraud Prevention Act.

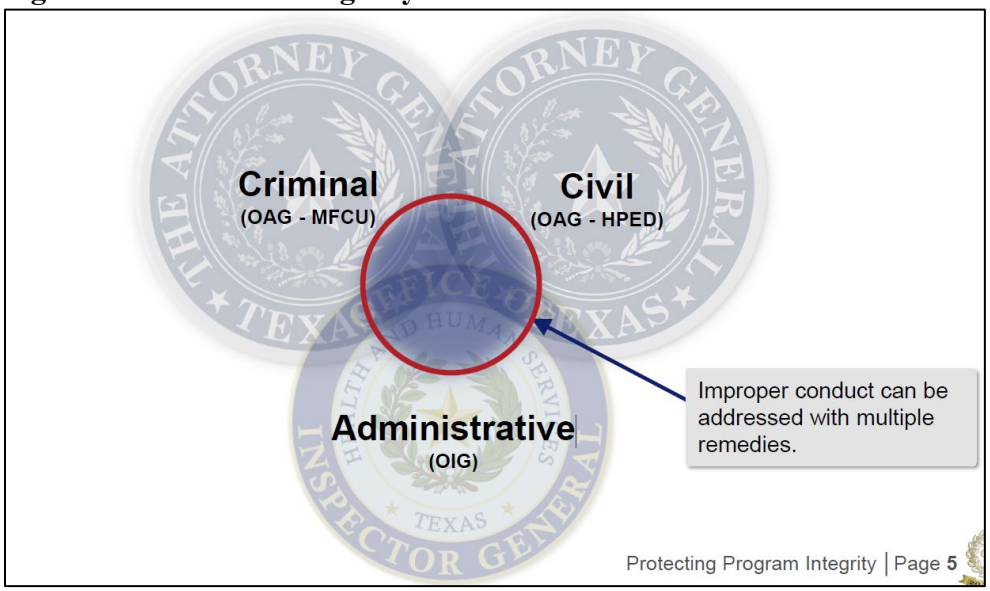
The Medicaid Fraud Unit (MFCU), housed within OAG, investigates criminal fraud, patient abuse, and neglect in Medicaid-funded facilities. The Health-Care Fraud Division investigates allegations of civil (non-criminal) unlawful acts against the Medicaid program (and other state-funded health programs) and prosecutes meritorious claims with the goal of recovering taxpayer dollars and prosecuting offenses.

In addition to state agency partners, OAG's MFCU collaborates with federal authorities, including the U.S. Justice Department's Health Care Strike Force, the Federal Bureau of Investigation, the Drug Enforcement Agency, and U.S. Attorney's Offices across the state.

Amy Hilton, division chief of the Health Care Unit at OAG explained to the committee that many of their cases are generated from whistleblowers or referrals from the OIG and HHSC.

Figure 15 illustrates how these agencies tackle issues from these three remedy arenas, and certain conduct may be prosecuted under all three areas: administrative, civil, and criminal statutes.

Figure 15: Texas State Agency Medicaid Fraud Collaboration



Source: *The Office of the Inspector General, Texas Health and Human Services Commission*

OIG guards $50 billion a year in health and human services spending, the majority of which is the Texas Medicaid program: $38 billion in all funds. Inspector General Raymond Winter explained that about 30 percent of the Texas budget is comprised of health and human services spending, and Medicaid encompasses about a quarter of it.[1]

"Our goal is to protect taxpayer dollars and ensure that real people receive the benefits provided by the legislature," he stated, noting that the National Health Care Anti-Fraud Association estimates that up to 10 percent of total healthcare expenditures are lost to fraud each year, meaning that up to $5 billion in Medicaid funds are diverted away from their intended purpose each year in Texas.

[1] Raymond Winter, Office of the Inspector General at the Texas Health and Human Services Commission, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.

OIG has 591 employees housed within 25 locations across the state, carrying a variety of functions, including investigations, utilization reviews, audits, inspections, data analysis, and litigation. OIG has recovered more than $407 million and avoided more than $173 million in costs through more than 18,000 different investigations into providers in the Medicaid programs as well as those engaged in fraud with the federal Supplemental Nutrition Assistance Program (SNAP).

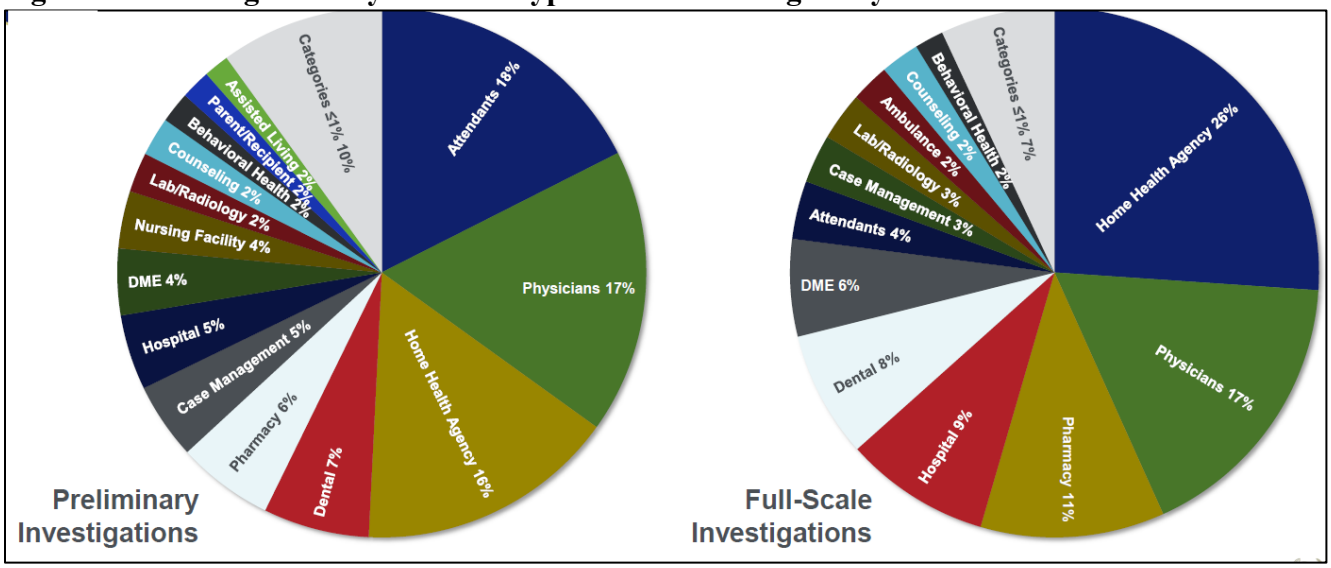
Winter noted that the OIG "exceeded" its performance metric, achieving a return on investment of about $5.44 for every dollar spent on operations. However, the recoveries are only a fraction of the estimated total fraud, waste, and abuse present in the Medicaid system.

Since 2000, OAG has recovered more than $2.6 billion under the Texas Health Care Fraud Prevention Act.

In FY 2024 alone, the OAG's Healthcare Program Enforcement Division has recovered $43,711,127. In FY 2023, the MFCU flagged $124 million in Medicaid overpayments, obtained more than $51 Million in fines and court-ordered restitution, processed over 2,400 referrals and achieved 79 criminal indictments, 64 arrests, and 61 convictions [2]

The federal government provides three-to-one matching funds for investigating and prosecuting fraud, waste, and abuse, but Texas is often limited in these efforts by the matching requirement.

Figure 16: Investigations by Provider type FY 2024 through July



***Source**: Office of the Inspector General, Texas Health and Human Services Commission*

Dudensing told committee members that managed care organizations work closely in partnership with HHSC, OIG, and OAG, driving better success in preventing fraud, waste, and abuse in Medicaid.

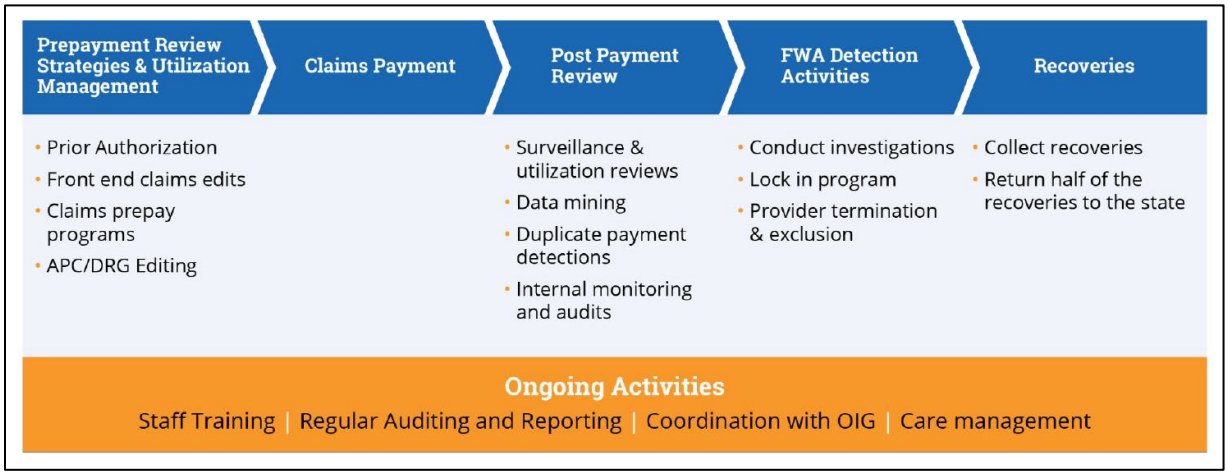
[2] Amy Hilton, Office of the Attorney General, *Testimony before the Texas Senate Committee on Health and Human Services*, September 18, 2024.

From 2009 to 2017, Dudensing stated that MCOs have saved up to $13.9 billion in Medicaid funds through effective fraud, waste, and abuse management. MCOs employ strategies and tools to prevent fraud.[3]

"We're leveraging technology to catch issues earlier rather than relying solely on a pay-and-chase model," Dudensing told the committee. Prior authorizations in managed care are an essential tool, she stated, for combating fraud, waste, and abuse. MCOs also analyze claims patterns to discern if there are fraudulent billing or "upcoding" practices.

MCOs are required to investigate all fraud, waste, and abuse cases and report them to the OIG within 30 days. Other activities—including updates on active cases, recovery efforts, and "pre-payment" reviews of Medicaid claims—must be made monthly to the OIG.

Figure 17: Medicaid Managed Care Organization Fraud, Waste and Abuse Activities



(Note: APC: Ambulatory payment classification (APC); DRG: Diagnosis-related group (DRG); Lock in Program: limits a Medicaid client to one provider/pharmacy for services if there is a history of misuse of Medicaid services.)
Source: *Texas Association of Health Plans*

Witnesses explained to the committee how inaccurate claims in Medicaid can lead to high reimbursement or coverage for services that may not be a Medicaid benefit. However, not all inaccurate claims are seeking to commit fraud or abuse.

"If we had evidence that the …provider knew they were making a misrepresentation or acted with reckless disregard or conscious indifference to the truth," that scenario would prompt the OIG to seek to recover "more than just the amount of loss" in Medicaid funds, Winter said.

Dudensing explained that when physicians authorize medications in Medicaid that are only covered for a specific diagnosis, data analysis may reveal abuse or fraud when connecting the authorizations to the patients who have claims for the actual diagnosis.

[3] Jamie Dudensing, Texas Association of Health Plans, *Testimony before the Texas Senate Health and Human Committee*, September 18, 2024.

Conclusion and Recommendations

Texas Medicaid has a robust partnership among several state agencies to ensure fraud, waste, and abuse are identified, investigated, and eradicated across the state. The Office of Inspector General at HHSC and the Office of the Texas Attorney General testified that the current structure of enforcement enables their agencies to work in concert with the Medicaid program and managed care organizations across administrative civil and criminal arenas and hold Medicaid providers and clients accountable.

Committee members asked the panel of witnesses what other tools or penalties might be needed to ensure that Texas effectively recovers lost Medicaid funds and prevents future losses.

Winter noted that he believed the current enforcement remedies—$10,000 per violation in addition to the amount of the actual Medicaid loss, plus three times that number—are strong; however, the OIG's primary enforcement statute has not been updated since the 1980s. “We intend to propose changes to modernize our statutory management authority, equipping us with the tools necessary to better protect this program.” The state should modernize the current fraud statutes to seek out increasingly sophisticated schemes.

Investments in technology tools and program staff can also expand the reach. The OAG’s MFCU unit garners almost $50 for every state tax dollar invested in its enforcement activities.

Dudensing testified that the committee members should expand support for tools like Artificial Intelligence and other data analysis technologies to enhance fraud, waste, and abuse strategies and to expand the Texas Fraud Prevention Partnership to include private health payers as well.

INTERIM CHARGE VI: PROTECTING VULNERABLE TEXANS IN EMERGENCIES

Protecting Vulnerable Texans in Emergencies: *Examine commercial residential settings for the elderly and individuals with intellectual disabilities, including assisted living facilities, boarding homes, group homes, and independent living communities. Identify emergency preparedness and response protocols required during severe weather for these populations. Make recommendations, if necessary, for the establishment and enforcement of emergency protocols to ensure vulnerable populations are protected.*

Introduction

The Texas Senate Committee on Health and Human Services conducted an interim hearing on November 13, 2024, to examine commercial residential settings for the elderly and individuals with intellectual disabilities and to identify emergency preparedness and response protocols required during severe weather for these populations. The charge specifically focused on how emergency responses unfolded during recent natural disasters such as Hurricane Beryl, which occurred in July 2024.

Experts from state and local agencies were invited to testify and to educate members of the committee on current emergency preparedness and response requirements for regulated providers, as well as recommendations for future disaster response for residential healthcare settings. Additionally, Entergy Texas, Inc. was invited to testify on ways to increase access to electrical generation in times of disaster.

Background

During emergency weather events, such as Hurricane Beryl, the Texas Department of Emergency Management (TDEM) works in concert with local authorities as well as the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) to oversee emergency response in healthcare settings.

During Hurricane Beryl, TDEM and other emergency response officials expressed concern over the length of time that long-term care facilities and other homes for senior citizens had no electrical power to support critical services and keep air conditioning operational during an intense summer heat wave.

TDEM and local agencies responded to numerous calls for help from various commercial living environments where elderly or medically fragile individuals were living. TDEM identified problems regarding knowledge around what types of facilities could have critical access to electricity and where priority efforts for reconnection should be focused. Additionally, confusion existed over the types of facilities required to have backup generation and how long backup generation was required to last. Though several laws and administrative codes implemented new

generation requirements, the length of time that Houston-based facilities lacked power exhausted those requirements.

HHSC's Long-Term Care Regulatory Division oversees a variety of residential settings that serve elderly and disabled Texans. These include:

- Nursing facilities;
- Assisted living facilities;
- Day activity health services;
- Intermediate care facilities, which include 13 state supported living centers;
- Prescribed pediatric extended care centers;
- Home and community support services agencies (i.e., home health, hospice); and
- Home and community-based (HCS) and Texas home living waiver service providers.

The state's licensing rules establish minimum requirements for the written emergency preparedness and response plan that each type of licensed provider must have. The long term care division develops and enforces regulatory emergency preparedness rules for these facilities. Additionally, the following facilities must comply with federal emergency preparedness requirements:

- Medicare certified hospice or home health agencies;
- Medicaid certified intermediate care facilities for individuals with an intellectual or developmental disability (IDD) or related condition (ICF-IDD); and
- Medicare or Medicaid certified nursing facilities.

These facilities have varying degrees of oversight.[4] Nursing facilities (NF), assisted living facilities (ALF) and intermediate care facilities (ICF) are required to be licensed to operate. HHSC conducts the licensing process and enforcement of the requirements, which include annual inspections and compliant inspections.

HCS waiver homes and host homes are operated by providers contracted by HHSC. Providers that operate these residences under the HCS waiver program are funded by Medicaid for individuals with IDD. A provider may operate a three-to-four bed "group home" within an HCS waiver as long as they are able to meet contractual and Texas Administrative Code requirements, which include:

- The ability to provide all services under the waiver;
- Submit to an annual survey which includes a life/safety examination of the homes;
- Conduct background checks on employees; and
- Establishing an emergency plan for disaster or weather events.

These may also operate more than four-beds as an ICF, which is a licensed category. Texas has 748 of these types of providers. Three and four-bed HCS "Group Homes" can be located in

[4] Michelle Dionne-Vahalik, Texas Health and Human Services Commission, *Testimony before the Texas Senate Committee on Health and Human Services*, November 13, 2024.

residential neighborhoods, or even within apartment complexes, and are designed to have a home-like atmosphere, which is less prescriptive than other facility-based operations.

This category of provider may also operate "host" homes for eligible IDD clients. In this scenario a provider employs a family to care for an eligible client. In Texas, there are upwards of 15,000 host homes.

Additional types of housing—including private homes that serve disabled individuals, which may be known as "boarding homes" and apartments, condominiums and "independent living" facilities that can be located in a campus-like setting along with other types of housing and cater to senior citizens—are not regulated by the state. Cities and counties that choose to adopt the full array of model standards published by HHSC are required to report information biennially to the state. However, there may be more cities and counties that have adopted the full array of standards and are not reporting to the state. In other words, we're only as good as what is reported.

Table 10: HHSC Regulated Long-Term Care Operations

Provider Types	Count of Providers	Approximate Count of People Served
Nursing Facilities (NF)	1,193	86,061
Assisted Living Facilities (ALF)	2,004	49,574
Intermediate Care Facilities (ICF)	748	5,392
Home and Community Services (HCS) There are three provider-operated residence types: • 3-person residences: 1,899 • 4-person residences: 1,217 • Host home and companion care: 15,397 **Total**: 18,513	900 —	30,584 (Including individuals living in their own homes.)

Source: *Texas Health and Human Services Commission*

Summary of the Testimony

During emergencies, HHSC's long term care division (LTC) performs a number of duties to address concerns over life and safety at these facilities.

HHSC communicates with the Texas Department of Emergency Management and local first responders through the State Operations Center to determine how to aid these facilities, when assistance is needed. This assistance includes providing critical information to providers through emergency broadcast system, coordinating any evacuation assistance, and addressing unmet needs (fuel for generators, water, etc.) for providers.

The LTC regulatory division also initiates call-downs (daily to weekly, depending on disaster and impact) to providers in affected areas to determine their status, resident safety, and whether resources are needed. It assists providers in finding alternate locations for evacuation if necessary. Finally, it conducts annual emergency preparedness and response training to survey staff.

Emergency Preparedness Requirements

Nursing Facilities

Every nursing facility in Texas must develop and implement a written emergency plan that accounts for all potential emergencies relevant to their operations and geographic area.[5] The emergency plan must be evaluated annually and within 30 days after an emergency or when the facility is remodeled. Staff must be fully trained on the plan within 30 days of assuming job duties, at least once per year after that, and any time a staff member's responsibilities under the plan change.

At least one unannounced drill must be conducted with staff each year. The plan must address eight core functions of emergency management:

- Direction and control;
- Warning;
- Communication;
- Sheltering arrangements;
- Evacuation;
- Transportation;
- Health and medical needs; and
- Resource management.

Certain facilities are required to have back-up power generation. As of 1996, every state regulated nursing facility is required to have the generator but does not have to support heat and air conditioning except in certain circumstances, HHSC Associate Commissioner for Long-Term Care Regulation Michelle Dionne-Vahalik explained.

For Texas nursing homes a generator must be present and be able to power:

- Alarm systems, such as fire alarm systems and oxygen alarms;
- Lighting for means of egress, nurse stations, medication rooms, dining and living rooms, and areas immediately outside exit doors;
- Exit signs, including means of egress directional signs;
- Selected electrical receptacles in corridors, at least, and in each resident bedroom in newer facilities;
- Nurse call system;
- Night lights, in resident rooms in newer facilities;
- Elevators, including cab lighting, control systems, and communication systems;

[5] Texas Administrative Code 26 §554.1914

- Telephone equipment; and
- Public address systems, if used in an emergency communications plan.

Generation requirements do not require backup power for critical care equipment or HVAC temperature control systems except in certain circumstances.

If a generator is used to power the above items, state licensure requires regular maintenance and testing of the generator. However, if ventilators are used within a facility, Federal rules mandate that the operator must have a generator and at least 96 hours of fuel on hand to keep automatic life support powered.

Dionne-Vahalik noted the caveat around "generator" requirements for nursing facilities. In areas of the state where the 99 percent design temperature is below 20 degrees Fahrenheit, a generator must support heating parts of the facility for resident safety. Fifty-four counties in Texas meet this requirement and, therefore, must be able to power heating services with a generator when the power is out.

Moreover, a nursing facility must have enough fuel to run the generator continuously for at least four hours. The facility must consider previous outages and plan for fuel delivery problems due to weather, shortages, and other geographic and environmental conditions.

Assisted Living Facilities

Assisted living facilities (ALFs) are another type of licensed, long-term care facility that can range in size from small residential facilities—serving four to six people—to larger buildings that can serve up to 150 individuals. Approximately half of the 2,000 licensed ALF providers in Texas are small-bed facilities, which typically appear as homes in traditional neighborhoods. The remaining ALFs are larger facilities that appear as more traditional, institutional care settings.

Assisted living facilities must have a written emergency preparedness and response plan that addresses the eight core functions of emergency management, which are the same as those of nursing facilities and ICFs.[6]

The plan must ensure communication with the local emergency management coordinator, both as a preparedness measure and during a developing disaster or emergency. These facilities must fully train staff on the emergency preparedness plan at least annually and conduct at least one unannounced annual drill with staff.

Large facilities (licensed for 17 or more residents) must have access to emergency power, which can be:

- A generator or a battery, battery-powered system, or battery-powered equipment. Emergency power must provide energy to:
- Fire alarm systems;
- Lighting in means of egress; and

[6] Texas Administrative Code 26 §553.275 Emergency Preparedness and Response.

- Exit signs and means of egress directional signs.

Both nursing facility and assisted living facilities are required to stock a minimum amount of non perishable food. Nursing homes must have a minimum of seven days of food, while assisted living requires a four-day minimum. Both types of facilities are required to have ample amount of drinking water on hand to sustain life during a disaster.

Intermediate Care Facility

An intermediate care facility (ICF) is a licensed provider that serves individuals with intellectual and developmental disabilities (IDD). All 13 Texas state-supported living centers (SSLC) are licensed as ICFs and certified under the Centers for Medicare and Medicaid Services (CMS).

ICFs must have an emergency plan that contains the required core elements, including evacuation, and that facility staff is trained on how to carry out the plan. HHSC does not approve or deny an individual facility's emergency plan, but rather that the plan exists, meets the required criteria and has been filed with HHSC.

ICF emergency plans must address the eight core components that both nursing facilities and assisted living facilities must meet: direction, warning, communication, sheltering arrangements, evacuation, transportation, health and medical needs, and resource management.

HHSC enforces this requirement by holding the provider responsible if the plan did not include certain components or if the provider failed to follow the plan. Facilities would be cited for a "violation" of licensing rules and subject to penalties.

Home and Community Services Providers

Every HCS residence must have and maintain an emergency preparedness plan that addresses potential emergencies relevant to the geographic area, the specific needs of their residents, and any specific threats, such as fire drills or evacuations and other relevant emergencies. Providers certified under the CMS must comply with disaster tracking and reporting requirements.

All staff for these providers must be trained on the emergency preparedness plan, and documentation of this training must be accessible to all staff members at the residence.

HCS homes are not required to have backup generators. However, if an individual in the home relies on equipment like oxygen or a ventilator, the residence must provide a backup plan, such as having extra oxygen tanks available in case of power failure.[7] If the needs of the residents cannot be met, the home is required to evacuate and relocate the residents.

[7] Michelle Dionne-Vahalik, Texas Health and Human Services Commission, *Testimony before the Texas Senate Committee on Health and Human Services*, November 13, 2024.

HHSC's LTC regulatory division actively participates in emergency preparedness calls with TDEM and other response agencies and LTC providers. These calls often occur multiple times a day leading up to a potential disaster (e.g., hurricanes or winter storms).

HHSC designates emergency contacts for key staff members within the LTC division for coordination efforts and notifies providers to ensure they are registered and compliant with emergency broadcast orders.

If a disaster impacts a particular area, HHSC will track the providers in that area to ensure they are following evacuation orders if necessary and safe relocation is achieved. After a disaster, HHSC will continue to track providers until the situation is resolved and residents are safely repatriated, ensuring all necessary reports are made to relevant authorities.[8]

Unlike other regulatory areas (e.g., intermediate care facilities for individuals with IDD), there is no formal complaint intake structure for HCS providers. HHSC enforces these requirements through the annual survey process, which occurs once a year. If any violations are found, the provider is cited and must submit a corrective action plan.

Hurricane Beryl And Power-Related Vulnerabilities

During Hurricane Beryl in July 2024, the greater Houston region experienced issues related to prolonged power outages and extreme heat, which contributed to the deaths of individuals in long-term care facilities. These facilities housed residents who depended on critical care equipment such as ventilators, oxygen, dialysis machines, and other critical care facilities.

Harris County Fire Marshall Laurie Christensen noted that over 100 residents in one facility were affected by the weather event and electricity aftermath, with 52.3 percent of the impacted individuals in the 60 to 79 age range. She noted that the problem with existing emergency plans is that facilities lacked sufficient emergency power systems (such as backup generators) and heat-related complications contributed directly to the deaths and suffering of these individuals.

Although many facilities maintain emergency plans, these plans sometimes fail in practice. Emergency services, such as fire departments, were overwhelmed with calls for help due to the high demand for evacuations during the disaster.

HHSC reported the number of facilities it called and tracked during Beryl.[9] For nursing homes: HHSC called over 397 nursing facilities and tracked over 100 of those nursing facilities that were impacted by Beryl. It called over 765 assisted living facilities, and tracked over 260 of those providers and called "hundreds" of HCS residential providers. Some of those providers chose to evacuate their facility with their clients and shelter in another location such as a hotel or a "sister" facility location.

[8] *Ibid.*
[9] *Ibid.*

Some HCS clients evacuated to stay temporarily with their family. Dionne-Vahalik reported that there were a handful of homes impacted by the power outages and had to make long-term preparations. But no deaths occurred in the facilities that HHSC oversees, Dionne-Vahalik stated.

Christensen noted that many of the calls for help came from apartments or other facilities that cater or advertise to senior citizens but provided no assistance or had no communication with those residents, many of whom were left in darkness and without electricity for many days. These facilities are not regulated by HHSC, but some do receive federal tax credits through the Texas Department of Housing and Community Affairs (TDHCA).

TDHCA Executive Director Bobby Wilkinson explained how the agency oversees the implementation of tax credit housing in Texas. TDHCA is the authorized state allocating agency for low-income housing tax credits, the main financing tool for new construction and rehabilitation of multifamily affordable housing. The tax credits are allocated by the IRS to each state and provide a significant source of equity funding to help developers build communities across the state.

In Texas, 29 percent of TDHCA's active multifamily portfolio—2,701 properties and 74,923 units—are for seniors. As the designated state allocating agency for these tax credits and as directed by state and federal law, TDHCA is also required to perform asset management and compliance functions for these properties.

Yet none of the seniors-focused apartment complexes referenced in the news reports during Hurricane Beryl as having residents stranded without power or who died were facilities that received tax credit support under TDHCA's jurisdiction. "To our knowledge all of those units were either market rate or subsidized by some other funding source," said Wilkinson.

Federal law prohibits facilities that have residents who need "continual or frequent nursing, medical or psychiatric services," such as nursing facilities, from receiving tax credits. These facilities are not under the jurisdiction of TDHCA.[10]

TDEM highlighted the challenges that local first responders face when attempting to provide aid during storms or other emergency events to facilities or entities that house vulnerable populations.

"At the local level, [first responders] have no idea of the facility that they're walking into: how it's licensed, how it's regulated, who owns it, if there are people inside caring for other people that are inside. … [M]y plea to you is to help us change that," said TDEM Chief Nim Kidd.

TDEM suggested that facilities—whether large apartments or regulated entities that cater to vulnerable population—need to be tagged and registered in the IT systems dispatch systems first responder organizations.

While some of these facilities had no back-up power, the rules and regulations that required generation at nursing homes and other facilities demonstrated progress, according to Kidd. "I think

[10] Bobby Wilkinson, Texas Department of Housing and Community Affairs, *Testimony before the Texas Senate Committee on Health and Human Services*, November 13, 2024.

during this storm is the first time we've actually had people call the state operation center and ask for things like fuel for my generator. …That's a good thing. That meant they had a generator there to begin with," he said. "… [So] progress is being made in so many of the licensed or regulated areas."

The Office of the Texas Long Term Care Ombudsman noted in testimony that 32 percent of the state's nursing facilities had back-up power generation connected to power heating, ventilation, and air conditioning (HVAC) systems and 38 percent of assisted living facilities had the same.

However, many of those facilities still needed fuel, hardware support for generators, water, ice, and other materials to help allay the impacts of prolonged power outages. The fewer of those requests that have to be addressed, the more capacity the state and its first responders have to address the critical needs of life and death. Some electrical providers can provide cost offsets for certain electrical customers to have back-up generation though a pilot program currently operating under the authority of the Texas Public Utility Commission.[11]

Both Christensen and Kidd noted that unregulated or unlicensed facilities are a major blind spot in emergency first response efforts. Kidd urged a "sensible solution" to help localities be able to know which places in Texas have individuals or organizations that are being compensated to take care of vulnerable people and how those facilities can be tracked to make emergency response more efficient to save lives.

During public testimony, Steven David, deputy chief of staff to Houston Mayor John Whitmire, explained how the city created an *ad-hoc* geospatial map to track apartments or other types of multi-family housing developments that are private and unregulated but are "marketed" to senior citizens in various ways. In Harris County, they found nearly 2,500 apartment complexes fell into that category. Of those units, 135 were receiving tax credits.[12]

Many of these facility owners or operators did not respond to emergency requests for assistance. This data is now being used to help city departments enforce city regulatory requirements and ensure that these facilities address emergency planning, David noted.

Another challenge in Texas is that there may be different types of regulated and unregulated facilities at a single address point. "If I'm pulling up to '123 Walk Street,' and it's a giant complex, within that [single] address point, there can be different levels of regulation, different levels of ownership, [and] different types of care that is or is not provided," Kidd said.

In the case of facilities that are receiving tax credits to provide certain types of housing that serve senior citizens, there are no requirements for the owners or management of those entities to be "onsite." The requirements only speak to the responsibility of the management to maintain the property.[13]

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[11] Stuart Barrett, Entergy Inc, *Testimony before the Texas Senate Committee on Health and Human Services*, November 13, 2024.
[12] Steven David, Office of the Mayor, City of Houston, *Testimony before the Texas Senate Committee on Health and Human Services*, November 13, 2024.
[13] *Ibid.*

Although the hearing focused on emergency response, the committee received public testimony concerning challenges within certain types of housing for individuals with Intellectual and Developmental Disabilities.

Several public witnesses relayed safety problems within the HCS certified three-bed and four-bed "group homes," asserting that their loved ones suffered neglect and injury as a result of the providers unable to care for resident with higher levels of need.[14]

Conclusion and Recommendations

Throughout the hearing, members of the Senate Committee on Health and Human Services and invited witnesses exchanged ideas on how to better address vulnerable populations and their needs in emergency events such as hurricanes, wild fires, or other disaster events.

Witnesses supported a proposal to creating a comprehensive list/registry of licensed, regulated, or certified facilities and facilities that receive compensation for taking care of individuals that can be disseminated amongst the agencies responding to emergency events. Policymakers could consider requiring certain facilities licensed, certified, or regulated by the state to pre-determine the level of back-up generators needed in an emergency, and establishing generation testing and maintenance requirements.

Several committee members suggested that entities receiving tax credits for providing certain housing to seniors have some responsibility to stay engaged and onsite for those residents during emergency disasters. Tax credit housing criteria should include such a requirement for the housing types that market and cater to elderly individuals.

However, for entities that are marketing specific residential services in multi-family buildings to senior citizens the state deceptive trade practices laws could be applied to ensure no vulnerable populations are being misled as to the housing those developments are providing the tenants.

During public testimony, the Office of the State Long-Term Care Ombudsman and advocacy organizations urged the committee to consider adding requirements for entities licensed, certified, or regulated by the state to provide backup electrical generation to support critical functions such as lighting, elevators, refrigeration for food, and temperature control.[15]

Finally, members of the public asked the committee to pass legislation to better regulate and oversee the "certified" IDD group homes under the HCS Medicaid waiver program by establishing licensing standards and enforcement for those facilities.

[14] Joan Brown, *Public Testimony before the Senate Health & Human Services Committee*, November 13, 2024.
[15] Patty Ducayet, Office of the State Long-Term Care Ombudsman, *Public Testimony before the Senate Health & Human Services Committee*, November 13, 2024.

APPENDIX A (WITNESS LIST)

Senate Health and Human Services Committee Witness List

May 14, 2024

Cancer Prevention Charge: *Identify and recommend ways to address the growing impact of cancer on Texans by evaluating state investments in cancer prevention and screenings including, but not limited to, "CT," "MRI," and "PET" scans. Study and make recommendations on funding adequacy for prevention efforts at the Cancer Prevention and Research Institute of Texas (CPRIT).*

Panel I

- **Dr. Manda Hall,** M.D., Associate Commissioner for Community Health Improvement, Texas Department of State Health Services
- **Kristen Doyle,** Deputy Executive Director and General Counsel, Cancer Prevention and Research Institute of Texas (CPRIT)
- **Dr. Ernest Hawk,** M.D., Vice President and head of the division of Cancer Prevention and Population Sciences, The University of Texas MD Anderson Cancer Center
- **Dr. David Wiseman,** Ph.D., MRPharmS., President, Synechion, Inc.

Health Insurance: *Examine the Texas health insurance market and alternatives to employer-based insurance. Identify barriers Texans face when navigating a complex health insurance market. Make recommendations that help individuals obtain healthcare coverage.*

Panel I

- **Cassie Brown,** Commissioner, Texas Department of Insurance
- **David Bolduc,** Public Counsel, Texas Office of Public Insurance Counsel
- **Dr. Brian Blase,** Ph.D., President, Paragon Health Institute

Panel II

- **Jamie Dudensing,** Chief Executive Officer, Texas Association of Health Plans
- **Dr. Ray Callas,** M.D., President, Texas Medical Association
- **Brad Holland,** President and Chief Executive Officer, Hendrick Health, for the Texas Hospital Association

Panel III

- **Si Cook,** Executive Director, Texas Farm Bureau
- **Meredith Duncan,** President and CEO, Texicare (Subsidiary of Texas Mutual Insurance Company)
- **Patrick Twohy,** Manager, Health Policy, Amazon
- **Dr. Katarina Lindley,** D.O. and FACOFP, Owner, Lindley Medical Direct Primary Care

September 18, 2024

Children's Mental Health Charge*: Review care and services currently available to the growing population of Texas children with high acuity mental and behavioral health needs. Make recommendations to improve access to care and services for these children that will support family preservation and prevent them from entering the child welfare system.*

Panel I

- **Dr. Andrew Keller,** Ph.D., President & CEO, Linda Perryman Evans Presidential Chair, Meadows Mental Health Institute
- **Dr. David Lakey**, M.D., Vice Chancellor, Professor of Medicine at The University of Texas at Tyler Health Science Center
- **Carolyn D. Gorman,** Paulson Policy Analyst, Manhattan Institute

Panel II

- **Stephanie Muth,** Commissioner, Texas Department of Family and Protective Services
- **Trina Ita,** Deputy Executive Commissioner, Behavioral Health Services, Texas Health and Human Services Commission
- **Dr. Ryan Van Ramshorst,** M.D., Chief Medical Director, Texas Health and Human Services Commission.
- **Shandra Carter**, Executive Director, Texas Juvenile Justice Department

Access to Health Care Charge: *Evaluate current access to primary and mental health care. Examine whether regulatory and licensing flexibilities could improve access to care, particularly in medically underserved areas of Texas. Make recommendations, if any, to improve access to care while maintaining patient safety.*

Panel I

- **Dr. Holly Jeffreys,** DNP, APRN, FNP-BC**,** Founder of Panhandle Family Care
- **Dr. Ray Callas,** M.D., President, Texas Medical Association
- **Jay Bueche**, RPH, Managing Director, Pharmacy Supply Chain & Managed Care, H-E-B
- **Dr. Hani Talebi,** Ph.D., LSSP, Psychologist, Incoming President of the Texas Psychological Association
- **Dr. Thomas Kim,** M.D., MPH, Chief Behavioral Health Officer, Prism Health North Texas

Panel II

- **Kathy Shipp**, MSN, APRN, FNP, President, Texas Board of Nursing
- **Julie Spier,** RPh, President, Texas State Board of Pharmacy
- **John K. Bielamowicz**, Presiding Member, Texas State Board of Examiners of Psychologists
- **Dr. Sherif Zaafran,** M.D., President, Texas Medical Board

Panel III

- **Dr. Varun Shetty,** M.D., Chief State Epidemiologist, Texas Department of State Health Services
- **Dr. John C. Goodman**, Ph.D., President & CEO of the Goodman Institute for Public Policy Research
- **Dr. Alicia Plemmons**, Ph.D., Economist & Assistant Professor, West Virginia University
- **Dr. Rebekah Bernard**, M.D., Family Physician and Author of "Patient's at Risk: The Rise of the Nurse Practitioner and Physician Assistant"

Monitoring Charge: *Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services passed by the 88th Legislature, as well as relevant agencies and programs under the committee's jurisdiction. Specifically, make recommendations for any legislation needed to improve, enhance, or complete implementation of the following: Initiatives to reduce Medicaid fraud, waste, and abuse, as well as other cost containment strategies; and Medicaid managed care oversight and accountability.*

Panel I

- **Emily Zalkovsky**, Chief Medicaid and CHIP Services Officer, Texas Health and Human Services Commission
- **Raymond Winter**, Inspector General, Texas Health and Human Services Commission
- **Susan Biles**, Principal Deputy Inspector General, Office of the Inspector General, Texas Health and Human Services Commission
- **Amy Hilton**, Chief of the Healthcare Program Enforcement Division, Office of Attorney General of Texas
- **William Marlowe**, Chief of the Medicaid Fraud Control Unit, Office of the Attorney General of Texas
- **Jamie Dudensing**, Chief Executive Officer, Texas Association of Health Plans

September 19, 2024

Monitoring Charge: *Monitor the implementation of legislation addressed by the Senate Committee on Health and Human Services passed by the 88th Legislature, as well as relevant agencies and programs under the committee's jurisdiction. Specifically, make recommendations for any legislation needed to improve, enhance, or complete implementation of the following:*

Senate Bill 7
Third Called Session, relating to prohibiting a private employer from adopting or enforcing certain COVID-19 vaccine mandates; authorizing an administrative penalty.

- **Ed Serna**, Executive Director, Texas Workforce Commission

Senate Bill 25
Relating to support for nursing-related postsecondary education, including scholarships to nursing students, loan repayment assistance to nurses and nursing faculty, and grants to nursing education programs.

- **Sarah Keyton,** Deputy Commissioner for Administration, Texas Higher Education Coordinating Board
- **Dr. Charles Contéro-Puls**, Ed.D., Assistant Commissioner for Student Financial Aid Programs, Texas Higher Education Coordinating Board

Senate Bill 24
Relating to the powers and duties of the Health and Human Services Commission and the transfer to the commission of certain powers and duties from the Department of Family and Protective Services.

- **Crystal Starkey**, Deputy Executive Commissioner, Family Health Services, Texas Health and Human Services Commission

Senate Bill 26
Relating to local mental health authority and local behavioral health authority audits and mental and behavioral health reporting, services, and programs.

- **Trina Ita,** Deputy Executive Commissioner, Behavioral Health Services, Texas Health and Human Services Commission
- **Susan Biles**, Principal Deputy Inspector General, Office of the Inspector General, Texas Health and Human Services Commission
- **Kacy VerColen**, Chief of Audit and Inspections, Office of the Inspector General, Texas Health and Human Services Commission

Senate Bill 1849
Relating to an interagency reportable conduct search engine, standards for a person's removal from the employee misconduct registry and eligibility for certification as certain Texas Juvenile Justice Department officers and employees, and the use of certain information by certain state agencies to conduct background checks.

- **Lisa Kanne**, Deputy Associate Commissioner for Operations, Texas Department of Family and Protective Services
- **Jordan Dixon**, Chief Policy and Regulatory Officer, Texas Health and Human Services Commission
- **Kaci Singer**, Deputy General Counsel, Texas Juvenile Justice Department
- **David Rodriguez**, Executive Director of Investigations, Texas Education Agency
- **John Hoffman**, Deputy State Chief Information Officer & Chief Technology Officer, Texas Department of Information Resources

November 13, 2024

Protecting Vulnerable Texans in Emergencies: *Examine commercial residential settings for the elderly and individuals with intellectual disabilities, including assisted living facilities, boarding homes, group homes, and independent living communities. Identify emergency preparedness and response protocols required during severe weather for these populations. Make recommendations, if necessary, for the establishment and enforcement of emergency protocols to ensure vulnerable populations are protected.*

Panel I

- **Nim Kidd,** Chief, Texas Department of Emergency Management
- **Laurie Christensen**, Harris County Fire Marshal, Harris County, Texas
- **Michelle Dionne-Vahalik**, Chief Policy and Regulatory Officer, Texas Health and Human Services Commission
- **Stuart Barrett,** Vice President of Customer Service, Entergy Texas, Inc.
- **Bobby Wilkinson**, Executive Director, Texas Department of Housing and Community Affairs

APPENDIX B (ADDENDUM LETTERS)

The Senate of Texas
CÉSAR J. BLANCO
TEXAS SENATOR
DISTRICT 29

December 9, 2024

Dear Chairwoman Kolkhorst,

I would like to express my gratitude to you and your team for your thorough evaluation of the critical healthcare issues presented in the interim report. Your leadership, along with the committee's comprehensive analysis, provides essential groundwork for addressing the pressing healthcare needs of Texans.

As our state continues to grow rapidly, the demand for innovative, evidence-based solutions to improve access to care becomes increasingly urgent. I commend the committee for examining the potential benefits of expanding practice authority during this interim period. Addressing these important issues not only enhances individual health outcomes but also strengthens the economic and social fabric of Texas.

The alarming shortage of healthcare providers, with 224 counties designated as Health Professional Shortage Areas (HPSAs), affects six million Texans, and the demand for primary care is projected to rise from 36% to 41% by 2036. While it is encouraging that Advanced Practice Registered Nurses (APRNs) are expected to be in surplus, restrictive practice laws significantly limit their contributions, especially in rural areas. Recognizing the vital role that APRNs play in meeting the critical need for primary care is essential. The report highlights that 27 states have adopted full practice authority for APRNs, resulting in improved healthcare access in underserved communities. With 76% of nurse practitioners specializing in primary and psychiatric mental health care, granting APRNs the ability to practice independently would directly address the increasing demand for these essential services and enhance the overall effectiveness of Texas' healthcare system. By expanding APRN practice authority, we can empower these skilled professionals to tackle shortages, improve access to care, and ultimately enhance the health outcomes of our communities.

The health benefits of expanding APRN practice authority are significant. Allowing APRNs to practice independently would lead to timely interventions, prevent conditions from worsening, reduce hospital admissions, and ease the burden on emergency services. This approach not only improves individual health outcomes but also promotes public health by creating a more responsive and efficient healthcare delivery system allowing for quicker responses to emerging health crises and better management of chronic diseases, both of which are critical for the long-term health of our state.

Moreover, economic data overwhelmingly supports the value of APRN-led care, which has been shown to improve affordability, enhance access, ensure quality, and promote economic growth in underserved areas. Research indicates that APRNs can provide primary and chronic care at a lower

CAPITOL OFFICE:
ROOM 3E.2
P.O. Box 12068
Austin, Texas 78711
(512) 463-0129

EL PASO OFFICE:
416 N. Stanton
Suite 700
El Paso, Texas 79901
(915) 577-0029

FORT STOCKTON OFFICE:
1618 Airport Dr.
Room 126
Fort Stockton, TX 79735
(915) 577-0029

cost than physicians while maintaining the same high-quality standards expected in our healthcare system.

The research presented in the interim report underscores the necessity of expanding the practice authority of Advanced Practice Registered Nurses (APRNs) to improve the well-being of all Texans. I am eager to continue collaborating with the committee and key stakeholders to develop a framework that effectively addresses our state's needs and enables APRNs to practice to the fullest extent of their training and education.

Thank you for your leadership on this crucial issue. I look forward to discussing this matter further and offering my support to advance this important initiative.

Sincerely,

César J. Blanco
Texas Senator
District 29

CAPITOL OFFICE:
ROOM 3E.2
P.O. Box 12068
Austin, Texas 78711
(512) 463-0129

EL PASO OFFICE:
416 N. Stanton
Suite 700
El Paso, Texas 79901
(915) 577-0029

FORT STOCKTON OFFICE:
1618 Airport Dr.
Room 126
Fort Stockton, TX 79735
(915) 577-0029

BORRIS L. MILES
STATE SENATOR • DISTRICT 13
COMMITTEES: CRIMINAL JUSTICE • HEALTH & HUMAN SERVICES • NATURAL RESOURCES & ECONOMIC DEVELOPMENT • NOMINATIONS • TRANSPORTATION

December 9, 2024

The Honorable Lois Kolkhorst
P.O. Box 12068
Capitol Station
Austin, TX 78711

Senator Kolkhorst,

I would like to thank you and your committee for your committee leadership through this interim and for putting this report together. This report is an accurate summary of the testimony given during the hearings and will undoubtedly assist policymakers in drafting bills for the upcoming 89th Session.

I am signing this report. With that being said, I take issue in general with one of the bills that the Committee was directed to monitor.

Statement Against SB 7

During the negotiations for this piece of legislation, I asked for one simple thing – allow hospitals and medical facilities to follow the advice of their own medical professionals and require mandated vaccines. As you know, I am an organ donation recipient. While this donation gave me the gift of a longer life, it has brought renewed danger regarding infection. I take daily medications that suppress my immune system in order for me to live my normal life. A Covid infection is not just inconvenient to me, it could be deadly.

SB 7 allows hospitals to require workers to wear PPE. While that is always helpful, medical professionals have repeated over and over that PPE is not a substitute for a Covid booster. Boosters do not prevent disease, but they make it harder to catch Covid and keep the disease more mild. Going to a medical facility is already stressful in itself, but immunocompromised individuals do not need the added layer of stress wondering if they may get infected and die.

CAPITOL OFFICE:
P.O. Box 12068
AUSTIN, TEXAS 78711
(512) 463-0113
FAX: (512) 463-0006
DIAL 711 FOR RELAY CALLS

CENTRAL HOUSTON OFFICE:
5302 ALMEDA ROAD, SUITE A
HOUSTON, TEXAS 77004
(713) 665-8322
FAX: (713) 665-0009

NORTHEAST OFFICE:
3300 LYONS AVENUE, SUITE 301
HOUSTON, TEXAS 77020
(713) 223-0387
FAX: (713) 223-0524

FORT BEND OFFICE:
2440 TEXAS PARKWAY, SUITE 110
MISSOURI CITY, TEXAS 77489
(281) 261-2360
FAX: (281) 261-4726

borris.miles@senate.texas.gov

Texas is a proudly pro-life state, but it should be pro-life for all people. I hope that we as a committee can re-visit this situation during the 89th Legislative Session and make sure that a child does not lose a parent or a parent a child due to an over-expansive idea of market freedom. The greatest asset of the State of Texas is its people and we need to do what we can to protect them. I look forward to working with you on this issue in the upcoming months.

Sincerely,

Borris L. Miles
Senator, District 13