



Interim Report

to the 84th Legislature

House Committee on
Human Services



January 2015

**HOUSE COMMITTEE ON HUMAN SERVICES
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2014**

**A REPORT TO THE
HOUSE OF REPRESENTATIVES
84TH TEXAS LEGISLATURE**

**RICHARD PEÑA RAYMOND
CHAIRMAN**

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Committee On
Human Services

January 6, 2015

Richard Pena Raymond
Chairman

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The Honorable Joe Straus
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

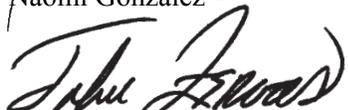
Dear Mr. Speaker and Fellow Members:

The Committee on Human Services of the Eighty-third Legislature hereby submits its interim report including recommendations and drafted legislation for consideration by the Eighty-fourth Legislature.

Respectfully submitted,


Richard Peña Raymond

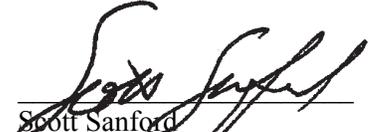

Naomi Gonzalez

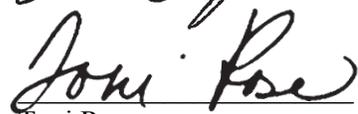

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INTRODUCTION

During the early stages of the 83rd Legislative Session, the Honorable Joe Straus, Speaker of the Texas House of Representatives appointed nine members to the House Committee on Human Services. The Committee's membership is comprised of State Representatives: Richard Peña Raymond, Chairman; Naomi Gonzalez, Vice-Chair; Elliott Naishtat, John Zerwas, Scott Sanford, Pat Fallon, Toni Rose, Scott Turner, and Stephanie Klick.

During the interim, the committee conducted five public hearings in Austin to consider the assigned interim charges. During each of the hearings, committee members heard invited and public stakeholder testimony. The invited testimony included input from agency executive leadership, advocates, and others with specific expertise on the charge. It was the also the practice of the committee to allow state agency leadership in attendance an opportunity to immediately respond on the record to specific policy-related questions directed to the committee during public testimony. This strategy often resulted in the agency official providing answers and explanations real time to all potential stakeholders in attendance and watching on the web.

It should also be noted that in addition to the formal public hearing process, committee members and/or their staffs often met individually with agency staff and public and private stakeholders on the issues related to each of the committee's interim charges.

The committee would like to thank each individual who took the time to provide invited and/or public testimony before the committee. The committee also wishes to acknowledge the work and coordination on the committee's behalf by the executive leadership and staff of the Health and Human Services Commission, Department of Aging and Disability Services, Department of Family and Protective Services, Department of Assistive and Rehabilitative Services and the Department of State Health Services.

The following report contains a summary of the committee's findings and recommendations.

INTERIM CHARGE ONE

Examine Crisis Resources for individuals with co-occurring mental illness and intellectual/developmental disabilities. Identify strategies to serve individuals with complex behavioral and medical needs in the community.

CHARGE DESCRIPTION

Mental health professionals, advocates and affected families have long associated the terms “co-occurring” or “dual diagnosis” with individuals suffering from mental illness and a substance abuse disorder. In practice today, however, the term is often used to describe persons diagnosed with an intellectual/developmental disability (I/DD) and a co-occurring mental illness.

The co-existence of intellectual and/or developmental disabilities and a psychiatric disorder can have serious effects on the person’s daily functioning by interfering with educational and vocational activities, by jeopardizing residential placements, and by disrupting relationships. In short, the presence of behavioral and emotional problems can greatly reduce the quality of life for persons with intellectual or developmental disabilities.

Due of the complex nature of accurately diagnosing persons with I/DD with a co-occurring mental illness estimates of its incidence vary greatly. However, the rate for mental health conditions for those with I/DD is generally thought to be two to three times higher than for the general population. ¹

Percentage of Individuals with Dual Diagnosis by IDD Waiver/FY 2013

IDD WAIVER	TOTAL SERVED	NUMBER WITH DUAL DIAGNOSIS	PERCENTAGE
HCS	21,044	8,201	39.0
TxHmL	5,623	1,522	27.1
CLASS	4,811	1,081	22.5
DBMD	157	16	10.2
TOTAL	31,635	10,820	34.2

Source: DADS

SSLC Residents with Mental Health Needs

FISCAL YEAR	END OF YEAR ENROLLMENT	PERSONS WITH MH NEEDS	PERCENTAGE W/MH NEEDS
2013	3,547	2208	62%

Source: DADS

A Legislative Budget Board/Government Effectiveness and Efficiency Report, 83rd Legislative Session found I/DD Local Authorities (LA) are encountering increased demand for safety net services. LAs estimated spending an average of 17 percent of their state funding on crisis services in fiscal year 2013. Some of the challenges in providing these services identified by the Texas Council of Community Centers included:

- Shortage of psychiatric specialists and board-certified behavior analysts statewide.

-
- Shortage of persons with experience in serving clients with dual I/DD and mental illness diagnoses.
 - Shortage of after-hours crisis intervention and stabilizations services; and limited emergency respite options.

Crisis services are designed for short-term use to stabilize immediate emergency crises. These services can include crisis hotlines, mobile crisis response teams, or short-term hospital admissions. Immediate access to emergency crisis services for dually-diagnosed individuals beyond the required 24-hour, emergency crisis hotline can often depend on where the person lives. Unfortunately, some individuals lack immediate access to coordinated emergency crisis services which has led to jail incarcerations of persons who otherwise could have been better served by mental health professionals or in a clinical setting.

Additionally, law enforcement crisis transportation of clients in need of rapid stabilization has been a resource repeatedly identified by local community stakeholders as one that can be strengthened. Factors which make this an issue are that the private hospitals are often outside the jurisdiction of law enforcement or that law enforcement does not possess the manpower necessary to remain with clients needing medical clearances for state hospital admissions. On-duty peace officers frequently report spending a considerable amount of time in the ER's waiting for an alternative transportation plan to emerge or until the peace officers can make other arrangements within their chain of command.²

Definitions

In 2011, the 82nd Texas Legislature passed legislation adding the Person First Respectful Language Initiative to the Texas Government Code. It directed the Texas Legislature, the Texas Legislative Council, the Texas Education Agency and each health and human services agency to avoid using certain terms and phrases, such as “mentally retarded” and to replace those terms with preferred phrases, such as “persons with intellectual disabilities.”

The Department of Aging and Disability Services (DADS) defines “intellectual disability” as: “A usually permanent condition originating sometime between birth and age 18. The person's general intellectual functioning is significantly below average (roughly an IQ of 70 or below) and his or her behavior does not meet the level of personal independence and social responsibility expected of the person's age and culture.” Intellectual disability is diagnosed through the use of standardized tests of intelligence and adaptive behavior.

“Intellectual disability” is also defined in Texas statute as: “Significantly subaverage general intellectual functioning that is concurrent with deficits in adaptive behavior and originates during the developmental period.” The same section also defines a “person with intellectual disability” as: “A person determined by a physician or psychologist licensed in this state or certified by the department to have subaverage general intellectual functioning with deficits in adaptive behavior.” Additionally, “subaverage general intellectual functioning is statutorily defined as: “Measured intelligence on standardized psychometric instruments of two or more standard deviations below the age-group mean for the tests used.”³

Unlike mental illness, intellectual disability always is associated with limited intellectual capacity, it occurs before age 18, and it is a permanent condition. In contrast, mental illness is not associated with a particular level of intelligence, it may occur in a person at any age, and it is often temporary and treatable. Like all other persons, individuals with intellectual disability can become mentally ill and they can be treated for their mental illness.

According to DADS, “developmental disability” has varying definitions in federal and state code. For purposes of this committee report, however, DADS provided the following “general” definition: “Severe chronic disabilities that can be cognitive or physical or both. The disabilities appear before the age of 22 and are likely to be lifelong. ‘Developmental disabilities’ is an umbrella term that includes intellectual disability, but also includes other disabilities that are apparent during childhood.”

Federal law defines a developmental disability as a severe chronic disability of an individual that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments.
- Is manifested before the individual attains age 22. Is likely to continue indefinitely.
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency.
- Reflects the individual’s need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.
- An individual from birth to age nine, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria described above if the individual, without services and supports, has a high probability of meeting those criteria later in life.⁴

Those with developmental disabilities include persons with cerebral palsy, epilepsy, developmental delay, autism and autism spectrum disorders, fetal alcohol spectrum disorder, or any of hundreds of specific syndromes and neurological conditions that can result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with intellectual disabilities.

DADS also uses the term “related conditions” to refer to a list of conditions included under the developmental disability umbrella. DADS may periodically add a condition to the list based on a case by case clinical determination that an individual’s disability satisfies the criteria in the federal definition of a “related condition.”

Mental health illnesses are defined as severe disturbances in behavior, mood, thought

processes and/or interpersonal relationships. The types of psychiatric disorders persons with intellectual or developmental disabilities experience are the same as those seen in the general population, although the individual's life circumstances or level of intellectual functioning may alter the appearance of the symptoms.⁵

Some of the common types of diagnoses impacting mental health are:

Mood Disorders: The disorders are characterized by disturbance of mood as a predominant feature. Depression, bi-polar and mania are the major sub-categories of mood disorders.

Anxiety Disorders: This group of disorders is indicated by the presence of excessive fears, frequent somatic complaints and excessive nervousness that can interfere with functioning. Panic attack, agoraphobia, obsessive-compulsive and post-traumatic stress disorder are some of the major sub-categories of anxiety disorders.

Psychotic Disorders: This group of disorders is characterized by any of the following signs and symptoms: delusions, hallucinations, disorganized behavior and impairment in reality testing. Schizophrenia and schizoaffective disorder are two of the major sub-categories of psychotic disorders.

Personality Disorders: The group of disorders refers to enduring patterns of dysfunctional behavior. Symptoms typically present as personality traits that are inflexible, maladaptive and cause significant impairment or subjective distress. Paranoid, anti-social, borderline and avoidant are some of the major sub-categories of personality disorders.

Other psychiatric disorders include: somatoform disorders, factitious disorders, dissociative disorders, sexual and gender identity disorders, eating disorders, sleep disorders, substance abuse related disorders, impulse control disorders, dementia disorders, dissociative disorders, and disorders usually first diagnosed in infancy, childhood or adolescence.

Depression and anxiety are two of the most frequently identified mental health conditions in people with I/DD.⁶ Research also indicates a higher than average incidence of schizophrenia in persons with I/DD when compared to the general population.⁷ Post-traumatic stress is another significant cause for concern in this group.

Appropriate diagnoses are often complicated by physical health conditions. Additionally, acute medical conditions can create symptomology or precipitate "behavior disorders" that can appear to be mental illness. Appropriate diagnoses can be further complicated by limitations in the person's ability to conceptualize what they are experiencing and to verbalize symptoms.

Crisis Services Delivery

DADS contracts with 39 Local Authorities (LAs) to serve as the point of entry for intellectual and developmental disability programs, whether the programs are publicly or privately operated. Additionally, LAs provide or contract to provide an array of services for people with intellectual and developmental disabilities.

The Texas Department of State Health Services (DSHS) contracts with 37 Local Mental Health Authorities (LMHA's) and NorthSTAR to deliver mental health services in

communities throughout the state. NorthSTAR is a Medicaid managed care plan that serves seven counties in the Dallas Medicaid service region. The LMHAs provide services, including crisis services, to a specific geographic area of the state, called local service area.⁸ In most local service areas, the LAs and LMHAs are one in the same.

In Texas, a mental health crisis occurs during “a situation in which: “The individual presents an immediate danger to self or others; the individual’s mental or physical health is at risk of serious deterioration; or an individual believes that he or she presents an immediate danger to self or others or that his or her mental or physical health is at risk of serious deterioration.”⁹

Each of the LMHAs offers access to a crisis hotline 24 hours a day, seven day a week. Crisis hotlines are required to be manned by a qualified mental health professional in crisis services (QMHP-CS) to perform immediate screenings and assessments of individuals in crisis, including assessments to determine risk of deterioration and immediate danger to self or others.

Individuals experiencing a crisis, as determined by a QMHP-CS screening, must be assessed face-to-face or via telemedicine by someone who is at least credentialed as a QMHP-CS within one hour after the individual presents to the provider in a crisis, either via the crisis hotline or a face-to-face encounter. The QMHP-CS must provide ongoing crisis services until the crisis is resolved or the individual is placed in a clinically appropriate environment. If the individual requires emergency care services, as determined by the QMHP-CS’s assessment of risk of deterioration and danger, then the provider of crisis services must have a physician, preferably a psychiatrist, perform a face-to-face or telemedicine assessment of the individual as soon as possible, but not later than 12 hours after the QMHP-CS’s assessment to determine the need for emergency services.¹⁰

In addition to the crisis hotlines, Mobile Crisis Outreach Teams (MCOT) manned by teams of QMHPs-CS and other mental health professionals also provide services to persons in crisis, including individuals with I/DD. Each catchment area has at least one MCOT. Unfortunately, MCOTs can find it difficult to respond immediately to multiple crises occurring simultaneously, particularly in large or densely populated service areas. Other crisis outpatient services available in some catchment areas include: 23-48 hour observation, community crisis residential services, crisis stabilization units, and law enforcement crisis intervention teams.

Innovative approaches to providing clinical resources to individuals in crisis are also being utilized around the state. For example, Harris County MHMRA is using a Community Based Supports Team (CBST) to provide field-based crisis intervention services for consumers with IDD who are at risk of hospitalization, losing residential placement, dangerous living conditions, etc. The team, which consists of a licensed psychologist, registered nurse, and an applied behavior analysis specialist, provides either short-term stabilization for the individual and the family or a referral to more appropriate services.

Federally-Qualified Health Centers (FQHCs) serve as community safety nets in underserved communities across the state. Seventy of these facilities provide integrated behavioral and acute care at more than 300 sites to Medicare, Medicaid, CHIP, insured and uninsured individuals. Patients may also be eligible for services based on their family income and on a sliding fee schedule. Two FQHC “look alike” provide services at four additional underserved sites. “Look alike” offer FQHC-like services but do not receive all of the benefits of FQHC status, such as enhanced Medicaid reimbursements.

Additionally, 20 CMS-approved Delivery System Reform Incentive Payment (DSRIP) projects operated by 16 community centers across the state provide services to clients with I/DD and a co-occurring mental health diagnosis, including projects that focus on crisis intervention.

COMMITTEE HEARING

The House Committee on Human Services held a public hearing on June 4, 2014 in Austin to consider Interim Charge One.

STAR+PLUS Expansion (I/DD Acute Care Carve-In)

Prior to the beginning of testimony on the assigned interim charge, Chairman Raymond called on Health and Human Services Commission (HHSC) Associate Commissioner Chris Traylor to provide committee members with a status update on the planned September 1, 2014 statewide expansion of the STAR+PLUS Medicaid managed care program.

Under the expansion, persons with intellectual and developmental disabilities will get their basic health services (acute care) through a STAR+PLUS managed care health plan. Persons receiving long-term care services and supports through one of the various Medicaid waiver programs will continue to receive those services under the waiver.

The expansion will impact persons with I/DD who live in a community-based Intermediate Care Facility for Individuals with an Intellectual Disability or related conditions (ICF-IID) or, receive services through one of the following IDD waivers:

- Community Living Assistance and Support Services (CLASS);
- Deaf Blind with Multiple Disabilities (DBMD);
- Home and Community-based Services (HCS);
- Texas Home Living (TxHmL).

Commissioner Traylor focused his remarks on how the September 1, 2014 STAR+PLUS expansion would impact the I/DD community.

Commissioner Traylor said the agency was working closely with family members, services providers, and advocates to ensure the expansion went smoothly. The commissioner identified two major issues that were being addressed to ensure the expansion is not disruptive to persons with I/DD currently receiving services. One, he said, was awareness of the transition and understanding of how the managed care model will impact persons with I/DD, their families and their providers. The other primary area of concern is to ensure network adequacy, a term used to describe a Medicaid patient's existing access to in-network primary care physicians, specialists and medical services.

He also clarified at providers' request that the STAR+PLUS expansion will cover persons participating in the Texas Health Insurance Premium Payment (HIPP) program. HIPP helps families pay for private health insurance by covering a portion of their premiums and co-pays/deductibles when individuals see a Medicaid provider.

Committee members at the time were provided with an event timeline related to the enrollment of persons with I/DD into managed care. At the time of this report, introductory letters had been sent to Medicaid recipients with I/DD (May). In June, enrollment packets

went out with reminder letters sent out in July. By mid-August, persons begin selecting their managed care providers.

During the hearing, one of the concerns expressed by the committee was how the agency would gauge and ensure network adequacy and continuity of services prior to and during the rollout.

Gary Jessee, deputy director, Medicaid Program Operations, said the agency is addressing network development and adequacy by requiring MCOs to offer network contracts to any providers who have previously participated in the Medicaid program. A list of these providers was provided to the participating MCOs by HHSC. HHSC also provided the MCOs with a list of 40,000 providers who previously had an acute care fee-for-service claim for persons with I/DD enrolled in any of the 1915(c) waiver programs.

Jessee said HHSC was also working with the MCOs to ensure continuity of services during the transition for persons with I/DD. He said the MCOs would be provided with a three-year record of acute care services for each covered individual as well as individual service plans for persons with I/DD receiving long-term care services and supports through a waiver program. He assured committee members that services previously authorized for persons under the fee-for-service model would be honored by the MCOs during the transition.

Public testimony on the STAR+PLUS expansion included comments from George Linial, a nursing facility provider representative. Linial told committee members that language on a single standardized contract between nursing facility providers and STAR+PLUS managed care organizations had been finalized. However, he expressed concerns that the contract language related to Medicaid/Medicare Dual Eligible Demonstration Project (DEDP) is “confusing and unclear.”

Linial suggested that the MCOs use a separate process when contracting with nursing facility providers for Medicare services. Concerns were expressed about whether the DEDP could be effectively implemented by the planned March 1, 2015 carve-in date.

Interim Charge Testimony

The committee heard invited and public testimony related to Interim Charge I from more than two dozen witnesses including: family members of persons with intellectual and/or developmental disabilities, service providers, disability and mental health advocates and invited state agency and local authority representatives. A sampling of the testimony is included here.

DADS Commissioner Jon Weizenbaum provided the committee with a description of the existing state resources available to support persons with I/DD. The presentation included a summary of services and supports for persons with I/DD with mental illness and behavioral support needs. The services and supports included services provided by the LAs, state supported living centers, Community ICFs/IID (Intermediate Care Facilities for Individuals

with an Intellectual Disability or Related Conditions), Community IDD waiver services, including behavioral supports. Crisis-focused services and supports included safety net services provided by the LAs, home and community-based services (HCS) Medicaid waiver diversion slots.

Commissioner Weizenbaum also described some of the agency's planned activities. These included a Money Follows the Person demonstration proposal that will establish behavioral and medical technical assistance teams and enhanced community transition supports and a Rate Add-On pilot program for individuals with high medical needs who are transitioning from a State Supported Living Facility (SSLC) to a small ICF/IID or the HCS waiver program.

Total funding for behavioral health services for FY 2014-15 is \$2,648,314,394 -- a 16.2 percent increase over the previous biennium. Funding for mental health crisis services experienced a 31.2 percent increase from \$168.6 million in FY 2012-13 to \$221.2 million for the current biennium. DSHS used an additional \$25 million budgeted for crisis services to fund 16 new crisis facilities and enhance three existing facilities.¹¹

Speaking for the agency charged with administering the state's mental health services, DSHS Assistant Commissioner Lauren Lacefield Lewis said the agency's priority population are persons with a diagnosis of mental illness and significant functional impairment. These persons, and those experiencing a mental health crisis, are eligible for DSHS-funded services, she said.

Asst. Commissioner Lacefield also explained the challenges faced by the agency when serving people with I/DD and a co-occurring mental health condition. She said the separate local I/DD authority and local mental health authority contracts can be a barrier to better integrated services. Another challenge faced by DSHS in serving persons with co-occurring disabilities is that often these individuals have specialized treatment needs that can go undiagnosed or once diagnosed access to specialized treatment services can be limited or non-existent.

Richard A. Hernandez, representing ResCare Residential Services, blamed "strict and inflexible utilization control by DADS as an obstacle to greater access to long-term support for persons with complex behavioral needs." He said behavioral and psychiatric crisis intervention options are "extremely limited" which often results in the involvement of law enforcement.

Colleen Horton, policy program officer for the Hogg Foundation for Mental Health, testified that from a clinical perspective historical paradigms have created default systems of care that attempt to manage behaviors without addressing the underlying causes which can manifest as behavioral crises. Higher quality, comprehensive mental health and medical assessments are the first step to identifying causes of challenging behaviors and conditions, she said. Horton also stressed need for additional professional expertise in the I/DD and MH fields. Citing

2013 statistics, she said 207 of the 254 Texas counties have federal designation as Professional Shortage Areas for Mental Health.

Horton said additional attention should be paid to adverse events (trauma) in the lives of persons with I/DD and the impact it has on behavior as a strategy for preventing crises associated with a co-occurring mental health condition. She suggested increasing the use of trauma-informed care in the I/DD community as a means of preventing behavioral crises. Significant attention has been given to the importance of trauma-informed care for children in the child welfare and juvenile justice systems. The legislature also mandates certain levels of trauma training in both systems. A program that is trauma-informed:

- Realizes the impact of trauma and understands potential paths for recovery;
- Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
- Seeks to actively resist re-traumatization.¹²

Nancy Rosenau, PhD, executive director, EveryChild, Inc. stressed the need for crisis prevention in addition to crisis intervention. She said her organization through its contract work with HHSC, has become aware of “hundreds of children and young adults with I/DD and a co-occurring mental health condition whose families experienced crises that led to placement in congregate care.”

Ellen Bauman of Burleson spoke to committee members on behalf of her 21-year-old granddaughter, Cayla. Bauman explained the severe challenges her granddaughter faces because of her complex medical and behavioral needs. She also expressed frustration over the lack of flexibility in her granddaughter’s Medicaid HCS Waiver benefit which disallows dental provider payments.

Susan Murphree, senior policy analyst for Disability Rights Texas, said her organization supports the expansion of home- and community-based services and said the challenge is building the capacity in the community needed to meet complex medical and behavioral needs—in both a managed care and non-managed care environments. She suggested adding specific services and defining specific risks groups or levels of need, with proper assessment would promote timely access to specialized services, including those for persons with I/DD.

RECOMMENDATIONS

- For purposes of uniformity and transparency across all state programs, including crisis services, HHSC should study the benefits and feasibility of developing and utilizing standard definitions for the terms “Developmental Disability” and “Related Condition”.
- HHSC should expand awareness and the use of trauma-informed care for persons with I/DD.
- LAs and LMHAs should whenever feasible integrate training and education for personnel providing intake services, assessments, service coordination and crisis services.

INTERIM CHARGE TWO

Monitor the implementation of Foster Care Redesign. Evaluate its impact on the child welfare system in areas of the state where redesign is underway, including transition from the legacy system, foster family retention and recruitment, placement stability, permanency, and child safety.

CHARGE DESCRIPTION

With roughly 16,700 children in paid foster care, Texas has one of the largest child welfare systems in the country. ¹³ In 2011, the Texas Legislature directed the Department of Family and Protective Services (DFPS) to ‘redesign’ the way the agency delivers foster care services to those children. FCR does not impact approximately 11,000 additional children under state conservatorship who are in kinship care or other settings.

When children cannot live safely at home and no appropriate non-custodial parent, relative, or close family friend is willing and able to care for them, the court can give temporary legal possession to Child Protective Services (CPS). CPS temporarily places these children in foster care. Foster care settings include:

- foster family homes;
- foster family group homes;
- residential group care facilities; or
- facilities overseen by another state agency.

Although foster care is meant to be temporary until a permanent living arrangement is found, it can become permanent -- usually when a foster parent adopts or accepts permanent managing conservatorship of a child.

In early 2010, the DFPS joined other child welfare stakeholders in a joint effort to development recommendations for the redesigned foster care system that addresses some of the shortcomings of the existing legacy system and improves outcomes for children and their families. A Public Private Partnership (PPP) was formed to serve as the guiding body to develop recommendations for the redesigned system.

Twenty-six individuals from various child welfare stakeholder groups were selected for the PPP. DFPS received input from more than 3,000 individual stakeholders during the development phase. In December 2010, the PPP reached consensus on recommendations for the redesigned system. The recommendations submitted to DFPS are intended to develop a system that results in better outcomes for children, youth and families, increase accountability, quality and coordination of services in areas of need.

The PPP identified eight quality indicators to serve as the foundation for developing the redesigned foster care system.

- First and foremost, children are safe in their placements.
- Children are placed in their home communities.
- Children are appropriately served in the least restrictive environment that supports minimal moves for the child.
- Connections to family and others important to the child are maintained.
- Children are placed with siblings.
- Services respect the child’s culture.

-
- To be fully prepared for successful adulthood, children and youth are provided opportunities, experiences and activities similar to those of their non-foster care peers.
 - Children and youth are provided opportunities to participate in decisions that impact their lives. ¹⁴

The PPP recommendations and quality indicators served as building blocks for S.B. 218 (82nd Reg.) which established the process by which Foster Care Redesign (FCR) is to be implemented. FCR involves radically transforming the existing legacy foster care system by establishing over time what can be described as a statewide “managed care model” for providing foster care services. The model utilizes performance-based contracting as a means to incentivize quality services and improved outcomes for the child.

Under the FCR model, Texas moves away from the traditional open provider enrollment process for procuring residential child care services. Instead, DFPS competitively procures a “Single Source Continuum Contractor” (SSCC) for a specific geographic or “catchment” area. Each SSCC is a licensed child-placing agency responsible for providing a full continuum of residential services for all children who enter the foster care system in the SSCC’s catchment area. The SSCC is the only entity directly contracting with DFPS.

The transition to the redesigned system began in 2012. DFPS made tentative Single Source Continuum Contract (SSCC) awards to Providence Services Corporation of Texas (for-profit) and Lutheran Social Services of the South (non-profit) on June 20, 2012. Providence was tentatively awarded the SSCC for a non-metropolitan catchment area and Lutheran was tentatively awarded the SSCC for a metropolitan catchment area. In early August 2012, DFPS announced that it will not award an SSCC for a metropolitan area as a part of the initial RFP. ¹⁵

In January 2013, Providence and DFPS signed a five-year contract worth \$30 million per year for the Region 2/9 “rural” catchment area. Providence and DFPS then embarked on a preparation period during which protocols and placement infrastructure were developed.

Providence began assuming responsibility for new foster care placements in late August 2013. It should be noted that case management responsibilities remain with DFPS caseworkers under the FCR model.

On December 16, 2013, DFPS awarded the first metropolitan SSCC to ACH Child and Family Services (ACH) of Fort Worth. ACH will serve as the SSCC for Region 3b, a portion of DFPS Region 3 which includes: Erath, Hood, Johnson, Tarrant, Palo Pinto, Somervell and Parker counties. Transition of children in the state’s legacy system to ACH began July 1, 2014. New placements began on September 1, 2014. ¹⁶

The implementation of redesign in a catchment area occurs in three stages. The initial stage requires the SSCC to provide a continuum of foster care, Preparation for Adult Living (PAL) services and Supervised Independent Living (SIL) services. Those services continue in the

service/contract. A transfer of related financial resources from DFPS to the SSCC is intended to cover costs associated with the transferred tasks.¹⁷

The provider reimbursement rate in the FCR system is determined by creating a blended rate. As FCR is implemented, that blended rate will be combined with a case rate to create a single blended case rate for each geographic area.

- A blended rate is similar to an average per diem payment rate for all children in paid foster care regardless of service level or placement type.
- A case rate reflects the total number of days a child is expected to remain in paid foster care.
- The single blended case rate is calculated by multiplying the blended rate by the days of service represented in the case rate.

In the state's existing legacy system, each level of service (basic, moderate, specialized or intense) in combination with each placement type (child placing agency, general residential operation or residential treatment center) determines the reimbursement rate for a day of services.

On August 1, 2014, less than one year after assuming the SSCC for the Region 2/9 catchment area, Providence notified DFPS in writing that it was exercising the contract's opt-out clause to voluntarily terminate its contract. Providence was providing services for about 1,100 foster children in the 60-county catchment area. DFPS has since returned to contracting directly with providers for services.

Just weeks prior to receiving notice that Providence would exercise the opt-out clause, DFPS had notified Providence about several issues related to the performance of their contract. Some of those issues included missing performance targets on key goals such as placing siblings together and keeping children close to home, a failure to develop staff, a network of providers and a full array of services.¹⁸

At this time, the only catchment area in the state operating under the FCR model is the six-county, Region 3b. DFPS has indicated that it remains "committed to the principles of redesign."

On November 12, 2014, DFPS released a request for information (RFI) for the Foster Care Redesign effort.

According to DFPS, one of the objectives of the RFI is to obtain input on the composition of the proposed catchment areas as well as to solicit feedback on the strengths and opportunities available in each of these areas. DFPS will use the information, along with data analysis and an evaluation of existing stakeholder support in the potential catchment area to determine when and where to release the next request for proposal (RFP).

Evaluation Reports

The Texas Department of Family and Protective Services contracted with Public Consulting Group, Inc. (PCG) in July 2014 to conduct an analysis of SSCCs' related costs focused on the resource transfer provided to the Single Source Continuum Contractors (SSCCs).

In the first two Redesign contracts, DFPS transferred funds to the SSCC that were associated with the tasks that the SSCC took on – such as placement, foster adoption development and contract management. DFPS also expects the SSCC to enhance services. As part of the ongoing evaluation of Foster Care Redesign, the PCG reviewed the start-up, implementation, and on-going costs related to the transfer of funds to the SSCC.¹⁹

The project mandate focused on the resource transfer. The blended rate calculation and the effectiveness of the individual FCR models did not fall within its scope. Findings from the PCG report included:

- **Resource Transfer Components:** DFPS and the SSCCs have different understandings of what costs would be covered in the ongoing resource transfers, but both parties agree that the resource transfers do not include all costs incurred by the SSCCs. The resource transfer is intended to transfer tasks and associated resources to the SSCCs, rather than to prescribe a certain number of FTEs for the SSCCs' work or cover the costs the SSCCs incur. The resource transfer does not include funding related to tasks DFPS requires the SSCCs to perform (e.g., billing, community engagement, transportation). In addition, DFPS was not able to transfer funding associated with some of the positions that were transferred to the SSCCs, (e.g., fringe expenses for transferred FTEs).
- **Overlapping Tasks within the Redesign System:** Foster Care Redesign introduces a new entity, the SSCC, into the way services are purchased and provided. The implementation of this new entity results in some overlap of administrative and operational tasks (e.g., attendance in court, at placements, or in service planning meetings). While the entity's attendance at these events may be overlapping, the tasks performed differ which provides a greater opportunity for information sharing and coordination to enhance services to children in foster care. The resource transfer does not include costs associated with tasks performed by both DFPS and the SSCC. The resource transfer only transfers funds associated with tasks that DFPS no longer performs. The current model requires the SSCC to fully fund these overlapping tasks.
- **Clarity of Expectations for SSCCs:** DFPS state staff, DFPS regional staff, and the SSCCs have different understandings of the role of the SSCC within Foster Care Redesign. DFPS does not expect to buy the same system it currently provides. In redesigning the system, DFPS expects the SSCC to use the funds transferred to support an enhanced system for children served by the foster care system. It is realistic to expect to meet the goal of providing enhanced services, additional funding is needed to support this initiative. Expectations among other stakeholders (e.g., CPAs, judges, attorneys ad litem) may have been unrealistic, particularly in terms of outcome expectations during the first year.

The PCG report, released after Providence exercised its 30-day, opt-out clause in August, pointed out stark differences in the SSCCs' operating models. The report stated: "During interviews with both SSCCs, the variations between each agency were evident. For example, ACH has a lengthy history in the Fort Worth area with many years of experience and significant relationships with providers, donors, and other stakeholders. Our Community, Our Kids (OCOK), the entity within ACH responsible for redesign, has staff who are able to build on existing relationships and trust to enhance services to children in foster care. By contrast, Providence, although having a presence as a CPA in the Austin area, was new to the Region 2/9 catchment area and had few, if any, existing relationships to build upon. Providence also faced unique challenges related to the geographic breadth of the catchment area, which encompasses approximately a quarter of the state's land mass. While DFPS provided ongoing technical assistance during the startup and implementation phases, Providence's proposed model did not come to fruition and they were unable to control their costs."

In addition to the cost report, DFPS contracted with the Stephen Group to conduct an independent, third-party operational review of the agency. Findings and recommendations contained in the Stephen Group report were released in June 2014. Additionally, DFPS is currently undergoing Sunset review as part of the HHSC enterprise. The Sunset review staff report, released in August 2014, echoed many of the findings and recommendations contained in the Stephen Group report. However, neither of the two reviews specifically addressed FCR. In May 2014, House Speaker Joe Straus named nine legislators to the House Select Committee on Child Protection. The committee is charged with studying the incidence of abuse and neglect fatalities in Texas and making recommendations to protect children.

COMMITTEE HEARING

On April 15, 2014, the House Human Services Committee met in Austin to consider Interim Charge Two. More than 30 witnesses appeared before the committee and provided invited and public testimony related to the interim charge. A sampling of the testimony is included here.

DFPS Commissioner John Specia began the testimony by providing committee members with an update on the agency's foster care redesign efforts. Commissioner Specia, a retired Bexar County district judge, was hired to run the agency in December 2012.

Commissioner Specia said one of his first major decisions after taking over at the agency was whether to move ahead with selection of Providence (the only qualified bidder under an existing RFP) to operate the SSCC in Region 2/9 or begin the entire selection process again. He said he opted to sign a contract with Providence knowing it wasn't going to be perfect. Commissioner Specia told committee members that it was his decision to "keep going forward" with respect to the Region 3b SSCC.

Responding to a question about the agency's decision to continue the FCR rollout in Region 3b without the benefit of having performance data from the Providence SSCC, Commissioner Specia said the size of the state and the differences in the catchment areas necessitates that redesign efforts continue. Citing the differences between two catchment areas in terms of resources and geography, he said drawing comparisons prior to the January 2014 rollout in Region 3b would have been difficult. Additionally, the commissioner said he believes it will take the current contracts and at least a "couple more" in place before enough data can be collected to adequately evaluate how the model is performing in the various catchment areas. Initial performance data related to the Region 3b ACH contract will be available in late 2014.

"I am committed to changing the model because the current system is not working," the commissioner told the committee. He said too many kids are being placed in foster homes far away from their families and the state should do a better job of keeping them within their communities... in their own schools. "That is where we need to be," he said.

Commissioner Specia said the agency is learning from the Providence rollout and working to address difficulties the agency experienced with automation as it moves forward with the FCR in Region 3b. Improvements are also being made in the area of stakeholder communication, he said, including strengthening the agency's dialogue with the PPP.

Responding to a direct question about the grade he would give FCR rollout efforts, Commissioner Specia said based on the limited performance data so far he would give it an "incomplete."

Representatives from Providence and ACH also provided testimony. Providence SSCC Executive Director Robert Hartman's said the company has had successes in meeting target goals for maintaining child safety, shortening length of stays in emergency shelters and completing transfer of children from the legacy system to the SSCC. However, the company has also faced several transition challenges including:

- distances in Region 2/9;
- scarcity of foster care resources;
- data system delays;
- coordination of multiple parties in case planning and decision making;
- shifts in roles/responsibilities;
- resource transfers and rates.

Additionally, Hartman cautioned against scaling back or delaying the FCR rollout saying the resulting pilot project approach would hamper the ability of future SSCCs to develop provider networks and develop data that can be used to improve future rollouts.

ACH CEO Wayne Carson described the non-profit model in place in Region 3b. At the onset of his presentation, Carson stressed his desire to see implementation of FCR continue. He said FCR involves a totally new discussion about how services are coordinated and delivered. For example, Carson said under the legacy system 44 different agencies provide foster care to at least one child in ACH's seven-county catchment area. Under FCR, Carson said all 44 agencies can be brought together in a network designed to meet the needs of foster children as a whole. Another example Carson cited was utilizing the leverage that comes with representing 2,400 kids in their system to increase the services available in the community. He also mentioned a meeting between ACH network providers and the medical director for Cook Children's Medical Center to discuss how each foster child in ACH's catchment area can receive medical services from doctors who understand how to work with kids who have suffered trauma.

Alfonso Valarde, Executive Director, Child Crisis Center of El Paso testified that El Paso does not currently have a SSCC in place, however, he wanted to update the committee on what his community was doing in anticipation of FCR and also share some concerns.

Valarde pointed out that El Paso is the largest U.S. city that contains a major military installation (Fort Bliss) with its city limits. This, he said, presents unique challenges such as cultural differences which creates difficulties in recruiting and retaining foster families. He said 25 percent of the children that his agency serves are members of families stationed at Fort Bliss. Valarde expressed concern that El Paso does not have a local agency that has the capacity, financial or otherwise, to become an SSCC. He said the existing agencies are small non-profits without access to start-up capital. Discussions and meeting are being planned to help these agencies learn what they can do to prepare for a potential future rollout, he said.

Ashley Harris, representing Texans Care for Children, urged the committee to consider halting the continued expansion of privatization efforts until DFPS can ensure all potential

contactors can keep kids safe and promote positive outcomes. Harris testified that the proposal of new rules by DFPS is acknowledgement that tighter safety standards are needed.

Additionally, Harris said indicators used to evaluate SSCC performance do not meaningfully measure a child's well-being, nor do they measure progress towards safety and stable and permanent placements. She said strong indicators of quality service provision should be developed to more accurately determine if services provided by the SSCC have a positive impact on children and families. Harris also suggested that DFPS and the SSCC develop performance measures that address individual developmental assets that highlight social and emotional well-being and promote success.

Irene Clements, representing the Texas Foster Family Association, told committee members that after speaking with foster parents in Region 2/9 a few common themes emerged with respect to their experiences with FCR. These included:

- A perception of not being respected or even trusted with the children placed in their care.
- Shortage of important information on a child when they are called to consider a new placement.
- Too much redundancy with the FCR system causing waste of time and resources.
- Shortage of funding to support extensive travel and shortage of respite care availability.
- Strong oil-based economy and rural population does not support new recruitment of foster families.

Clements said she is also concerned about losing tenured foster families due to what she described as burdensome rules not related to child safety and well-being and a lack of flexibility for families within the redesigned system. She said foster families should be considered a part of the professional team charged with providing services to foster children and their birth families.

Adoption Process

At the committee's request, Commissioner Specia briefed the committee on the state's adoption process and efforts by the agency to make the process less restrictive. Adoption is one of three metrics used in the FCR model to evaluate permanency performance. The other two metrics considered when determining permanency outcomes are family reunification and kinship placement.

Families utilize two options for adoption in Texas:

- Private or independent adoptions and international adoptions are regulated by DFPS and involve children that are not in DFPS conservatorship.
- Child Protective Services (CPS) adoptions are also regulated by DFPS. CPS is responsible for finding adoptive placements for children that are in DFPS conservatorship.

Texas currently ranks second in the country in the number of children adopted, behind Alaska.²⁰ According to DFPS, 5,364 children were placed with adoptive parents during the 12 preceding months. The number of adoptions in Texas has risen 69 percent since 2005.

However, 3,832 children with terminated parental rights currently remain in DFPS conservatorship.²¹ Commissioner Specia told committee members that about 1,300 kids age out of the system each year. A number he described as “way too many.”

Since 1998, the federal government has incentivized states to place foster children with adoptive families. Texas has received \$46.4 million under the initiative since 1998.²² FCR also incentivizes the SSCC’s to move children safely towards a permanency outcome including adoption, reunification with their families, or permanent kinship placement.

Responding to questioning about the case record redaction process and delays it has caused in adoption cases, Commissioner Specia testified that during the last six months, the agency has acquired additional resources and hired additional personnel to eliminate the backlog, which can delay adoptions by several months.

The committee also heard testimony from representatives for Spaulding for Children and Gladney Center for Adoption, two private adoption agencies operating in Texas. Bruce Kendrick of Embrace Texas, a faith-based organization providing foster family and adoptive family support provided committee members with an overview of their efforts in the Dallas-Fort Worth area.

RECOMMENDATIONS

- The state should remain committed to redesigning the paid foster care service delivery system, but the FCR rollout should be temporarily delayed pending further evaluation of available data, additional PPP input, and possible legislative direction.
- The PPP should play a primary role in developing data-based refinements to the FCR model prior to each subsequent rollout.
- Prior to each subsequent rollout, DFPS should ensure that all tasks and related FTEs to be transferred from DFPS to an SSCC are clearly identified, agreed upon and fully funded, including fringe expenses for transferred FTEs
- DFPS should work with the PPP to develop future FCR catchment areas to ensure existing community-based systems and provider bases are preserved and their potential maximized.
- DFPS should dedicate an appropriate number of personnel within the agency's ombudsman division specifically assigned to address provider and consumer complaints, including allegations of abuse, within the paid foster care system.
- DFPS should continue the use of independent, third-party evaluation of FCR rollout until implementation is complete in one non-metropolitan catchment area and one large metropolitan catchment area.
- DFPS should set aside a portion of Federal Adoption Incentive dollars each budget cycle to be reinvested in sustaining adoptions by increasing the number of post-adoptive parent liaisons within each service region, focusing on those areas not currently served by a liaison.

INTERIM CHARGE THREE

Monitor and evaluate implementation of SB 7 (83R), including agency preparations for the statewide rollout of STAR+PLUS.

CHARGE DESCRIPTION

Senate Bill 7, (83rd Reg.) directs the Health and Human Services Commission (HHSC) and the Department of Aging and Disability Services (DADS) to jointly design and implement an acute care services and long-term services and supports system for individuals with intellectual and developmental disabilities through managed care.

S.B. 7 also expands other areas of Medicaid managed care, including:

- STAR+PLUS Medicaid Rural Service Areas (MRSA) expansion (statewide coverage);
- Nursing facility carve-in;
- Children with disabilities, and;
- Dual Demonstration.

STAR+PLUS is Texas' Medicaid managed care program for people who have disabilities or are 65 or older. The program is operated under the state's 1115 federal Medicaid waiver. People in STAR+PLUS receive integrated Medicaid health-care and long-term services and supports through a medical plan that they choose.

Implementation of the bill began in September 2013 and will roll out gradually over the next six years through 2020. The establishment of a standard functional assessment tool is a key component of the program.

Utilizing a managed care model and a focus on service coordination, the bill's goal is to provide health care and LTSS to more people by tailoring services to meet their health care needs in a cost-efficient way. S.B. 7 changes how the state manages and pays for Medicaid acute care services for persons with I/DD in the following 1915(c) waiver programs:

- Texas Home Living (TxHmL);
- Home and Community-based Services (HCS);
- Community Living Assistance and Support Services (CLASS);
- Deaf Blind and Multiple Disabilities (DBMD); and
- Medical services and LTSS in the Medically Dependent Children's Program (MDCP).

Additionally, individuals receiving services in community-based intermediate care facilities for individuals with intellectual disabilities or related conditions (ICF-IID) will also transition to STAR+PLUS.

With the expansion of STAR+PLUS, persons with I/DD who are receiving long-term services and supports will receive their basic medical services (doctor visits, hospital visits, and prescriptions) through a STAR+PLUS managed care health plan. Waiver program participants will continue to receive their LTSS through the various waivers. Persons with I/DD in the rural service areas already receive Medicaid acute care services through the STAR managed care model. Transitioning this group to STAR+PLUS will provide them access to expanded basic attendant and habilitation services through the Community First Choice Option when implemented in March 2015.²³ Persons in state supported living centers will not be impacted by the STAR+PLUS I/DD carve-in.²⁴

After the statewide expansion, the Community Based Alternatives (CBA) program now available in the Medicaid rural service areas will no longer exist. Adults who get long-term services and supports through the CBA program will get their basic medical services through a STAR+PLUS health plan. They will receive their home and community-based services through the STAR+PLUS HCBS waiver. An estimated 2,654 individuals on wait list for CBA will be immediately assessed for services through the STAR+PLUS waiver.

According to HHSC, 412,000 STAR+PLUS members are currently receiving services. An estimated additional 80,000 members will be served with the rural services area expansion (164 counties).

Three additional significant managed care expansions are set for March 1, 2015. Nursing facility services will be carved into the STAR+PLUS managed care model. The Community First Choice Option becomes available and the Dual Eligible Demonstration is set to roll out.

The goal of the nursing facility carve-in is to improve the quality of care and promote care in the least restrictive, most appropriate setting. Approximately 56,800 nursing facility residents will transition to STAR+PLUS.²⁵ Nursing facilities were originally set to be carved in on September 1, 2014, but the rollout was delayed due to insufficient testing of claims filing portals.²⁶ Texas has approximately 94,000 licensed nursing facility beds. Of that number, 55,200 are Medicaid-pay only, 5,100 are dual-eligible (Medicaid/Medicare) and 33,700 are either private pay or Medicare-pay only.²⁷

Every state receiving Medicaid funding is required to provide nursing home services, while community-based services are optional. Sixty seven percent of Medicaid long-term care dollars pay for institutional services, while the remaining 33 percent must cover all the community-based waivers, optional programs, etc.²⁸

Community First Choice (CFC) is a federal option that allows states to provide home and community-based attendant services and supports to Medicaid recipients with disabilities. CFC provides states with a six percent increase in federal matching funds for Medicaid for these services. Additionally, federal requirements mandate no waiting lists and no geographic restrictions.

The Texas Dual Demonstration project is a fully integrated managed care model for individuals who are enrolled in Medicare and Medicaid (dual-eligibles). One managed care plan will be responsible for providing both Medicare and Medicaid services. The goals of the project are to:

- have one health plan responsible for both Medicare and Medicaid services;
- improve quality and individual experience in accessing care;
- promote independence in the community, and
- allow shared savings between the state and federal government.

The Dual Demonstration project will be implemented in the following six counties: Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant and will affect approximately 132,000 dually-eligible individuals. About 500,000 Texans receive both Medicaid and Medicare services.

The STAR Kids Medicaid managed care program will target SSI-eligible kids under 21 years of age. Foster care children will continue to receive their health care services through the STAR Health Program.²⁹

*SB 7 Implementation Timeline 2014-2020*³⁰

September 1, 2014

STAR+PLUS expands statewide and I/DD acute care benefits transition into the managed care plan.

March 1, 2015

- Nursing facility services transition into STAR+PLUS.
- Community First Choice Options becomes available. (Conditional on Centers for Medicaid/Medicare Services approval of state plan.)
- Dual Demonstration Pilot Program begins.

September 1, 2016

STAR Kids and IDD pilot programs will be implemented.

September 1, 2017

Determination regarding transition of Texas Home Living (TxHmL) benefits to STAR+PLUS will be made.

September 1, 2020

Determination regarding transition of HCS, CLASS, DBMD, and community intermediate care facilities (ICF) in STAR+PLUS will be made.

Stakeholders including, program participants, family members of program participants, advocates, providers, and the managed care organizations (MCOs) played an integral part in the development of the legislation. As a mechanism for ongoing guidance, the bill establishes the I/DD System Redesign Advisory Committee to monitor planning and implementation of the bill's components over the next six years. DADS will rely on input from the redesign committee, along with input from other related stakeholders including the Promoting Independence Advisory Committee, to help guide and improve program implementation and service delivery. The bill also establishes the STAR Kids Advisory Committee, STAR+PLUS Quality Council and the State Medicaid Managed Care Advisory Committee to ensure additional stakeholder engagement.

Additionally, the bill includes the following safeguards:

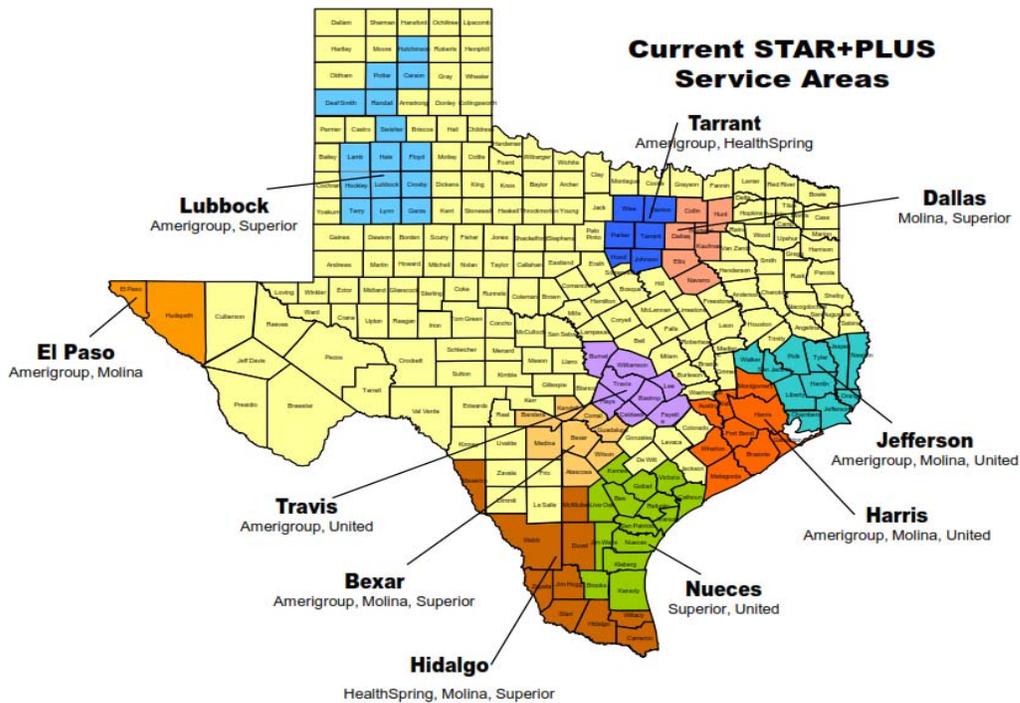
- New definitions for key terms that have a specific meaning to people with I/DD (“basic attendant services,” “habilitation services,” and “functional need”).
- A phased-in rollout period to provide for evaluation and improvement during each step of implementation.
- Voluntary enrollment in STAR+PLUS for children and young adults (SSI-eligibles under 21), people in the DBMD, HCS, and CLASS waiver programs. People in a waiver

program by 2020 can continue to get services through the waiver indefinitely, if they want. All others will get services through STAR+PLUS.

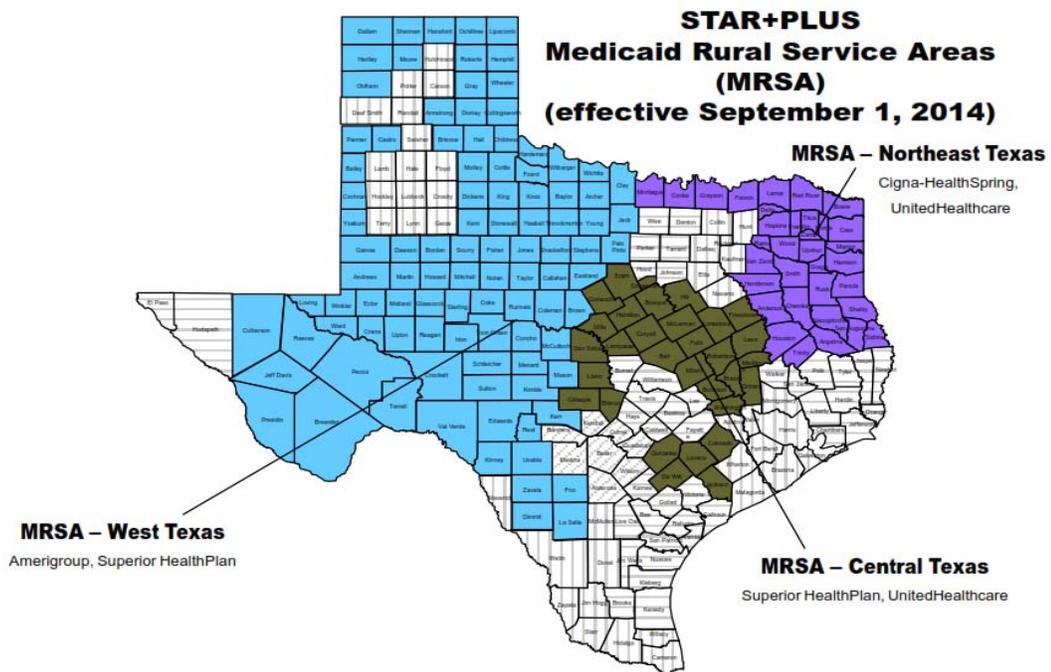
- HHSC can continue to operate Medicaid waiver programs or the Medicaid ICF-IID program to provide supplemental LTSS that STAR+PLUS doesn't provide.
- For CFC, functional needs assessments will be conducted by someone that is independent from the managed care organization (MCO) or service provider. The independent entity will also play a strong role in the Person-Centered Planning (PCP) process and provide independent case management (service coordination) services.
- DADS can evaluate functional need using an evidence-based, nationally-recognized assessment tool that is specifically designed for people with I/DD.
- New and continuous reporting requirements to allow stakeholders and state leaders to monitor the progress of the redesign rollout and make adjustments when needed.
- Emphasis on person-centered planning, self-direction and self-determination, community inclusion, fair hearings and appeals, local safety net providers and services, and community-based services for all, including people with the most significant service needs.
- No premiums to get medical or LTSS.

Additional parts of S.B. 7 apply to all Texans served in STAR+PLUS, not just people with I/DD. Significant components that will affect the entire population include:

- New outcome measures and incentives to improve the quality of services and reduce “potentially preventable events,” such as institutionalization.
- New advisory committees to focus on managed care services for people in nursing homes and children, as well as a new council to make policy recommendations on the quality of person-centered, consumer-directed acute care and LTSS in integrated settings under STAR+PLUS.
- A wellness screening plan for Medicaid recipients to establish a health baseline for use in treatment plan or health goals.
- Permission for local mental health authorities to use funds from the Texas Health Care Transformation and Quality Improvement Program waiver to serve children and adults with mental health conditions other than schizophrenia, bi-polar disorder and major depression.
- One new study by HHSC and/or DADS to determine the service needs for people with Prader-Willi syndrome.
- Determine feasibility of applying income disregards to people with I/DD in Medicaid waiver programs.
- Determine if it's cost effective to seek a waiver to provide services and supports to medically fragile people over age 21 whose costs are more than current waiver cost limits.



Source: HHSC



Source: HHSC

Statewide expansion of the STAR+PLUS Medicaid managed care model, including the carve-in affecting persons with I/DD, was implemented as planned on September 1, 2014.

COMMITTEE HEARING

The Committee on Human Services held a public hearing in Austin on March 24, 2014 to consider Interim Charge Three. More than 40 individuals provided invited and public testimony to the committee. A sampling of the testimony is included here.

HHSC Deputy Commissioner Chris Traylor and DADS Commissioner Jon Weizenbaum provided committee members with an overview of implementation efforts and answered numerous related questions.

Among the questions asked by committee members:

- What is HHSC doing to ensure network adequacy for the I/DD population?
- How will HHSC ensure adequate stakeholder input from across the state?
- How is HHSC enforcing provider payment delays?
- What is the STAR+PLUS expansion's budget implications?
- What is the enrollment process or individuals?
- How will DADS enforce nursing home standards once the carve-in is complete?

Speaking to how the agency will ensure network adequacy for the I/DD carve-in Commissioner Traylor said it will be vital that Significant Traditional Providers (STP) who have provided services for persons with I/DD in the past continue to do so. A STP is a provider identified by HHSC as having provided a significant level of care to the target population, in this case persons with I/DD receiving Medicaid. Commissioner Traylor said he hopes that the I/DD carve-in will result in more physicians being exposed to persons with I/DD.

Commissioner Weizenbaum told committee members that ongoing stakeholder participation is required under the provisions of the bill. He said the primary vehicle for stakeholder input was designed into the bill with the establishment of several advisory committees with specified membership intended to include representation from across the program spectrum. Although the bill creates its own advisory committees, he said, additional input from other stakeholders is not excluded and will be actively sought.

Responding to questioning from the committee regarding budget goals and the September 1 expansion and I/DD carve-in, Commissioner Traylor said budget implications with respect to the nursing facility carve-in are negligible as most savings accrued on the acute care side will go toward paying for nursing facility services. As for the STAR+PLUS expansion, he said about 18,000 new Medicaid recipients would be covered under the expansion. Commissioner Traylor said the overall impact on the budget once projected savings are factored in would not be significant.

As for enforcing payment claims delays, Commissioner Traylor said the agency primarily relies on liquidated damages (contractual penalties for failure to comply with predetermined performance standards) to enforce prompt pay requirements contained in the bill. He said

such arrangements have proven more efficient and timely with respect to contract provision enforcement.

Commissioner Weizenbaum said after the nursing facility carve-in his agency would continue to rely on liquidated damages to penalize nursing facilities for program violations. In response to questioning from the committee, he said the agency's lack of nursing home contract terminations due to serious violations was more due to federal Medicaid program rules requiring that violators be given the opportunity to take corrective action than the need to maintain an adequate nursing home provider base.

David Gonzalez, CEO, Texas Association of Health Plans told committee members of their efforts to work with providers, advocates and HHSC Medicaid program officials to ensure the transition of the I/DD community is smooth and without lapses in coverage. He referenced his group's experience with the STAR managed care model and said he is confident that experience and ongoing stakeholder input on the planned STAR+PLUS expansion will help streamline the effort.

Austin ADAPT organizer Bob Kafka said his organization continues to support the ideas behind S.B. 7. He said his hopes are that the state can establish a system that provides services based on a person's functional needs. Kafka said there are people who have had a stroke, or spinal or brain injuries or have Alzheimer's disease, who have disabilities and medical needs similar if not identical to those of a person "labeled" as developmentally disabled, but cannot qualify for similar services. Kafka stressed the need to place more emphasis on recruitment and training of personal attendants (PA). He said Texas pays PAs the floor of 7.86 per hour. He said the state should heed national calls to raise the minimum pay for attendants to 10.10 per hour by being one of the first states to do so.

Amanda Fredrickson, director of Advocacy, AARP, said her organization continues to support the S.B. 7 model, including the nursing home carve-in. She said they see the carve-in creating a "rebalancing" of the Medicaid system by changing the delivery model to encourage more community-based services rather than institutionalization. She said the managed care model would provide the incentives needed for the MCOs to increase community-based services and enable more people to remain at home instead of in an institution. She said the increase in the capitation rate paid to MCOS for the nursing home carve-in would give them the money they need to pay attendants more or provide for additional attendant hours. Fredrickson said she hopes the MCOs would see the potential benefits of paying attendants above the existing base rates required under their respective contracts with the state. She also said in the long-term DADS should consider giving the MCOs the authority to deny contracts to nursing facilities with numerous serious violations or considered to be chronic poor performers.

Representing about 450 profit and non-profit nursing home facilities throughout Texas, Kevin Warren, president and CEO, Texas Health Care Association, testified that his organization supports continued work towards a uniform nursing facility/MCO contract.

Since Warren's testimony, agreement has been reached on a uniform contract. He said his group is also appreciative of the decision to delay the nursing facility carve-in. Warren said the decision to delay will help ensure inadequacies are addressed and proper system testing occurs.

Dennis Borel, executive director, Coalition of Texans with Disabilities, said his organization continues to support the objectives of S.B. 7 for various reasons he has expressed in the past. Borel said he considers the Community First Choice Option (attendant/habilitation services) the single finest point in the bill. He said it moves new services to people who have been on waiting lists for long periods of time. Borel expressed concern that more could be done to reach out to those individuals in nursing facilities who will be impacted by the March 1, 2015 nursing facility carve-in.

Dr. Gilbert Handal of El Paso and representing the Texas Medical Association (TMA), said his group supports implementation of S.B. 7 and the associated efforts to address what he called the "hassle factor" which physicians face when serving the Medicaid population. Dr. Handal warned, however, of a "brewing perfect storm" in 2015. He said a number of factors impacting physicians will culminate next year and could result in severe strains on the acute care system for not only persons impacted by S.B. 7, but for the entire Medicaid population. Dr. Handal said conversion to electronic records capability has cost practices much more than previously expected. Additionally, compliance with additional HIPPA regulations, including associated training, and the October 2014 implementation of federal ICD-10 requirements are also proving to be expensive propositions for physicians, he said. ICD-10 is a revised coding of diseases, signs and symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization.³¹

RECOMMENDATIONS

- It is the committee's opinion that implementation of S.B. 7 should continue as planned using the timeline cited by HHSC and included with this report.
- This committee should continue to closely monitor the various managed care carve-ins required by S.B.7, and any resulting impact to service delivery.
- HHSC should require participating STAR+PLUS MCOs to adhere to network adequacy standards that to the greatest extent possible align with Medicare Advantage standards.
- HHSC should implement a single portal for provider claims submission and work with providers to decrease unnecessary paper-based claims.
- HHSC should work to increase its efforts to solicit and consider relevant stakeholder input as specifically called for in S.B. 7.

INTERIM CHARGE FOUR

Former foster youth have the benefit of free tuition and fees if they enroll in higher education, yet very few take advantage of this opportunity. Consider new strategies to support these youth and make recommendations to enroll and retain more foster youth in higher education. (*Joint charge with the House Committee on Higher Education*)

CHARGE DESCRIPTION

The Texas state tuition and fee waiver provides exemptions at state supported institutions of higher education to certain youth who were formerly in foster care, adopted, and who permanent managing conservatorship was granted to a non-parent (*Texas Education Code, Section 54.366 and 54.367*).

A student is exempt from the payment of tuition and fees if the student was in the conservatorship of the Department of Family and Protective Services:³²

- the day preceding the student's 18th birthday;
- the day of the student's 14th birthday, if the youth was eligible for adoption (parental rights being terminated) on or after that day;
- the day the student graduated from high school or received the equivalent of a high school diploma;
- the day the student was adopted if that date is on or after September 1, 2009;
- the day permanent managing conservatorship of the student was granted to an individual other than the student's parent, if that date is on or after September 1, 2009;
- the student enrolls in a dual credit course or other course which a high-school student may earn joint high school and college credit, and is in conservatorship on the day of enrollment.

Students covered by one or more of the criteria listed above must enroll in an institution of higher education as an undergraduate student not later than their 25th birthday.

Additionally, a student is exempt from the payment of tuition and fees if the student was adopted and is the subject of an adoption assistance agreement for monthly financial assistance and Medicaid under *Subchapter D, Chapter 162, Family Code*. This law primarily applies to students adopted prior to September 1, 2009.³³ According to DFPS, the benefit to qualifying for the waiver under this section is that there is no time limit for the student to enroll in an institution of higher education. However, students in this section must:

- Maintain a grade point average that satisfies the college/university's policy regarding eligibility for financial aid. (undergraduate and graduate students)
- Not complete credit hours considered to be excessive under Section 54.014, unless the college/university allows the student to do so on a showing of good cause. (undergraduate students only)

If the student does not meet the required grade point average or completes a semester with excessive hours, the student may not continue to receive the waiver for the next semester or term. The student can re-qualify for the waiver if the student completes a semester or term without receiving the waiver and meets the grade point average requirement and does not complete excessive hours during that semester or term.

According to DFPS, during 2013, 3,619 former foster youth and 1,006 adopted youth were utilizing the college tuition and fee waiver. Additionally, in 2013, 1,328 youth aged out of

foster care; 1,081 were identified as high school seniors; and 667 youth 18 and older exited foster care with a high school diploma or GED.

Participation Obstacles

A number of factors have been identified as barriers to additional participation in the program:

- failure to graduate from high school or receive a GED;
- lack of placement stability;
- school absenteeism and enrollment interruptions;
- lack of college preparation courses;
- lack of educational/career advocacy;
- housing costs; and
- difficulty navigating the higher education system.

Additional financial assistance available to foster youth is the federally-funded Education and Training Voucher (ETV). The ETV provides \$5,000 annually to eligible students and can be used to pay for room and board, child care, tutoring and transportation.

According to data provided by the Texas Higher Education Coordinating Board (THECB), Texas public colleges and universities provided tuition and fee waivers to 3,688 current and former foster youth worth approximately \$9.7 million in 2013. Costs are absorbed by each of the institutions. The number of recipients of tuition and fee waivers has increased 61 percent since 2009.

COMMITTEE HEARING

On September 4, 2014, the House Human Services Committee and the House Higher Education Committee met jointly to consider Interim Charge Four. The committees heard testimony from more than 30 witnesses providing invited and public testimony related to the charge. A sampling of the testimony is included here.

DFPS Commissioner John Specia described the program to committee members and explained the existing benefits available to foster children. He also briefed the committees on the obstacles foster children and families face with respect to increasing utilization of the tuition and fee waiver.

One of the issues Commissioner Specia said was a problem for foster children attending schools is housing, especially during holiday breaks and the summer when dorms are closed. Responding to questions from the committee about the efforts being made to engage the private sector and local churches, Commissioner Specia said his agency could do a much better job at that. He said the agency is working with their faith-based ministries and he will make this issue part of the discussions.

Commissioner Specia said in many instances, existing foster families continue to provide housing for foster kids attending college while they are on breaks. “A lot of foster parents do it,” he said. “A lot of these foster parents do not kick kids out at 18 or 21. Many kids do stay in their foster care arrangement through college. However, there are some who do not have that kind of arrangement.” He said supervised independent living arrangements may be another option.

Tiffany Roper, assistant director Permanent Judicial Commission for Children, Youth & Families, said data exchanged between TEA and DFPS supports what many have thought – foster students aren’t faring as well in school as they should.

According to 2011 TEA statistics, 57 percent of foster children graduated from high school under a degree plan meeting only minimum requirements. The statewide average for this category is 20 percent. Additionally, Roper said 42 percent of foster children graduate under a recommended plan compared to the statewide average of 67 percent. Only two percent of foster children graduate from high school under the distinguished plan compared to the statewide average of approximately 13 percent.

Roper suggested ensuring the Commission’s collaborative partners remain at the table with a continued commitment of resources on behalf of TEA and DFPS and others. She also suggested that work implementing the Texas Blueprint recommendations continues; particularly those related to postsecondary education.

In 2010, the Supreme Court of Texas issued an Order Establishing the Education Committee of the Permanent Judicial Commission for Children, Youth and Families (Children's

Commission). The Education Committee — a high level group of court, education, and child welfare decision-makers — created a collaborative initiative and produced a roadmap for us to follow, the Texas Blueprint: Transforming Education Outcomes for Children and Youth in Foster Care.

Monica Martinez, assistant commissioner for Standards and Programs, TEA briefed committee members of what TEA is doing at the secondary level to support foster youth in transitioning to higher educational opportunities. She said TEA has produced a printed guide and maintains a website to provide information on higher educational opportunities for foster youths. She also said each school district and charter is required to have at least one designated liaison in place to work directly with foster youth.

Jane Caldwell, director of Grants and Special Programs, Texas Higher Education Coordinating Board, stressed to the committee how important it is for foster youths to enroll in the tuition and fee exemption program before they reach the age of 25. Once they are enrolled, they can utilize the benefits indefinitely. She said each institution administers the exemptions—not the THECB.

Additionally, Caldwell said THECB does coordinate aggregate data related to number of youths using the exemptions and the dollar value of the tuition and fees provided. This report does not identify the student. Caldwell said her agency is attempting to collect individual foster youth student data through the Financial Aid Database. She said former foster youths who receive student financial aid, including the tuition/fee exemptions, can be identified using this database.

Dr. Vivian Dorsett, president, Texas Foster Care Alumni Association said she has been mentoring former foster youths at Prairie View A&M since 2008. Dr. Dorsett said many of the challenges foster care youths face do not even begin until they get to campus—particularly for those who no longer have association with their foster families. She said it is vital that these students have a “human connection” on campus that they can easily access. Once they leave the foster care system, Dr. Dorsett said, they often feel overwhelmed with the decisions and responsibilities they now face alone without the benefit of a family unit to lean on for guidance. She also suggested that former foster youths should not be pushed to utilize campus housing when enrolling in school. In an effort to address the housing issue, Dr. Dorsett said her university has established a supervised independent living program in which former foster youths, both students and non-students can participate.

Tymothy Belseth, a former foster youth who aged out of the system and a recipient of the tuition and fee waiver, said he changed high school six times and did not do well. In college, however, he said he thrived, graduating Summa Cum Laude with a double major in political science and sociology. Belseth said he then enrolled at UT-Austin where he is currently working on a Master’s degree in political science. He said access to the tuition and fee waiver was a vital component in helping him to reach his goals.

Belseth encouraged the committee to look at what other states have done to promote what he called ‘normalcy’ in the lives of foster youths. He said some state have enacted ‘normalcy legislation’ aimed at providing experiences for foster youths in conservatorship with the same experiences as their peer who are not in conservatorship. Additionally, Belseth said the legislation establishes a prudent parent standard to allow foster parents and caregivers to decide whether to allow the youth in their care to participate in everyday normal activities. Currently, he said, if a CPS service plan allows a youth to play football but the youth is injured playing tennis then the caregiver could be held liable for not following the service plan. While he said this may be good for the safety of the child, it does not promote socialization skills and normalized behaviors that will benefit the youth as they grow older. “This needs to change,” he concluded.

RECOMMENDATIONS

- THECB should implement a mechanism in the state’s common application for higher education for students to self-identify as former foster care youth so that institutions of higher education can inform them of their right to the exemption.
- The collaborative model between DFPS, TEA and other stakeholders for the K-12 foster youth population should be broadened to include postsecondary education stakeholders, including the THECB.
- DFPS should work collaboratively with stakeholders to implement a training program specifically designed to assist foster parents in navigating the state’s public higher education system.
- Colleges and universities should develop volunteer mentorship programs using former foster youths to support incoming students participating in the tuition and fee waiver program.
- DFPS and the THECB should collaborate to create a mechanism for tracking the outcomes of current and former foster youth who utilize the tuition and fee waiver.

CHARGE FIVE

Conduct legislative oversight and monitoring of the agencies and programs under the committee's jurisdiction, including implementation of the Balancing Incentives Program and relevant legislation passed by the 83rd Legislature. In conducting this oversight, the committee should:

- a. consider any reforms to state agencies to make them more responsive to Texas taxpayers and citizens;
- b. identify issues regarding the agency or its governance that may be appropriate to investigate, improve, remedy, or eliminate;
- c. determine whether an agency is operating in a transparent and efficient manner; and
- d. identify opportunities to streamline programs and services while maintaining the mission of the agency and its programs.

CHARGE DESCRIPTION

The House Human Services Committee has oversight responsibility for the following state agencies:

- Health and Human Services Commission (HHSC);
- Department of Family and Protective Services (DFPS);
- Department of Aging and Disability Services (DADS); and
- Department of Assistive and Rehabilitative Services (DARS).

Combined state expenditures for these agencies and DSHS totaled approximately \$76 billion for the 2014-15 biennium.

The five HHS System agencies have requested a total of \$83.8 billion from all fund sources for the two-year period of fiscal year 2016-2017, an increase of \$8.1 billion (10.7 percent) over the 2014-2015 biennium amounts. The General Revenue (GR) portion of the fiscal year 2016-2017 request totals is \$34.9 billion, an increase of \$4.4 billion (14.5 percent). Figures also assume a \$1.0 billion General Revenue supplemental appropriation (to cover Medicaid expenditures) in fiscal year 2015 along with \$1.6 billion in related federal funds.³⁴

The entire HHSC enterprise, which includes each of the agencies under the committee's exclusive oversight and DSHS, is currently undergoing the Sunset Review process. On December 10, 2014, the Sunset Commission, voted to approve Sunset staff recommendations to consolidate the functions of DFPS, DADS, DARS, and DSHS into HHSC. If subsequent legislation is approved and signed into law, the stand-alone agencies would be eliminated and would instead exist and operate as program divisions within HHSC.

The plan approved by the Sunset Commission will be drafted into legislation and considered by the full legislature during the 84th Regular Session.

COMMITTEE HEARING

Throughout the interim, the Human Services Committee monitored the agencies under its jurisdiction. Additionally, on September 3, 2014, the committee met to consider and discuss various topics and programs under development at the respective agencies.

HHSC officials provided the committee with an update on implementation efforts related to the Dual Eligible Integrated Care Demonstration Project. Douglas Wilson, HHSC Inspector General appeared before the committee and answered several questions related to what some on the committee perceived as a lack of due-process rights afforded to Medicaid providers facing overpayment holds and/or credible allegations of fraud.

DADS Deputy Commissioner Chris Adams briefed the committee on the status of the Balancing Incentive Program (BIP). BIP increases the Federal Medical Assistance Percentage (FMAP) to participating states through September 2015 in exchange for states making certain structural reforms to increase access to Medicaid community based long-term services and supports (LTSS). These required structural reforms include:

- implementing a "no wrong door" eligibility and enrollment system;
- developing core standardized assessment instruments; and
- ensure case management activities are conflict free.

The goal of BIP is for the state to spend more than 50 percent of Medicaid LTSS funds on community-based services by October 2015.

DFPS Commissioner John Specia briefed members on the decision by Providence Service Corporation to exercise its "opt-out" clause and relinquish its contract to serve as the SSCC for FCR Region 2/9. Commissioner Specia said the agency has since returned to contracting directly with foster care providers in the region.

DARS Commissioner Veronda Durden provided the committee with information related to the agencies ongoing initiatives, including implementation of Rider 30 which directs DARS to report on the actual number of consumers served by each Center for Independent Living (CIL) in fiscal year 2014, and the projected numbers of consumers served by each CIL in FY 2015.

RECOMMENDATION

- The committee supports the recommended due process and transparency reforms impacting the HHSC Office of Inspector General unanimously adopted by the Sunset Commission at its December 10, 2014 public meeting.

ENDNOTES

- ¹ Horton, Colleen, Policy Program Officer, Hogg Foundation for Mental Health, Testimony, House Human Services Committee Interim Hearing, June 4, 2014.
- ² ACCESS MHMR Crisis Services Plan, Revised 2012
- ³ Sec. 591.003, Texas Health and Safety Code
- ⁴ The Developmental Disabilities Assistance and Bill of Rights Act (DD Act) of 2000 (P.L. 106-402)
- ⁵ American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision*
- ⁶ Davis, e., Saeed, Antonacci, D. (2008). Anxiety disorders in Persons with Developmental disabilities: Empirically Informed Diagnosis and Treatment. *Psychiatric Quarterly*, 79, 249-263.
- ⁷ Cooper, S.A. et al., (2007). Mental Ill Health in Adults with Intellectual Disabilities: Prevalence and Associated Factors. *The British Journal of Psychiatry*, 2007, 190: 27-35.
- ⁸ Department of State Health Services
- ⁹ Texas Administrative Code, §412.403 Definitions
- ¹⁰ TAC, §412.321, Crisis Services
- ¹¹ Department of State Health Services
- ¹² Substance Abuse and Mental Health Services Administration
- ¹³ Texas foster care redesign, initial insights into foster care reform, April 2014
- ¹⁴ Foster Care Redesign Report, DFPS, 2010
- ¹⁵ Texas Foster Family Association, Redesign Update,
- ¹⁶ DFPS, House Human Services Committee hearing presentation, April 15, 2014
- ¹⁷ DFPS, Child Care Administrator's Conference, October 2012
- ¹⁸ DFPS, Press Release, August 1, 2014.
- ¹⁹ DFPS
- ²⁰ Administration of Children and Families, Children's Bureau Child Welfare Outcomes Report
- ²¹ DFPS, Testimony, House Human Services Committee hearing, April 15, 2014
- ²² DFPS, Testimony, House Human Services Committee hearing, April 15, 2014
- ²³ HHSC, Testimony, House Human Services Committee hearing, March 24, 2014
- ²⁴ HHSC, Testimony, House Human Services Committee hearing, March 24, 2014
- ²⁵ HHSC, Testimony, House Human Services Committee hearing, March 24, 2014
- ²⁶ HHSC, Testimony, House Human Services Committee hearing, March 24, 2014
- ²⁷ DFPS
- ²⁸ American Disabled for Attendant Programs (ADAPT)
- ²⁹ HHSC, Testimony, House Human Services Committee hearing, March 24, 2014
- ³⁰ HHSC
- ³¹ Medicaid.gov, ICD-10 Overview
- ³² DFPS
- ³³ DFPS
- ³⁴ HHSC Consolidated Budget Request, October 2014

