Greg Abbott's Healthy Texans Plan

Women's Health

Recommendation: Add optional screening and treatment for postpartum depression to the types of services covered by CHIP Perinatal and Medicaid for low-income pregnant women.

Recommendation: Increase funding for Texas women's health programs to expand the types of services covered for eligible women enrolled in the program.

Services for Survivors of Sexual Assault and Abuse

Recommendation: Increase appropriations to the Office of the Attorney General to increase by 100 the number of newly-certified Sexual Assault Nurse Examiners (SANEs) who are trained each year to provide an improved level of care and compassion for victims, along with careful evidence collection and the expertise needed for effective prosecution.

Recommendation: To provide more services and greater protection for victims of domestic abuse, create Domestic Violence High Risk Teams, which unite law enforcement, medical professionals and victim advocates at the local level to review cases of domestic violence, and identify, monitor, and contain the most dangerous perpetrators before they can inflict deadly harm.

Mental and Behavioral Health Care

Recommendation: Extend loan forgiveness programs to mental health professionals who practice in underserved areas.

Recommendation: Offer designated mental and behavioral health screening days for veterans and service members near military installations.

Disability Services

Recommendation: In order to recruit and retain personal attendants, and provide home- and community-based living options, increase pay for personal attendants.

Increasing Accountability of Benefits

Recommendation: Transform social service delivery and provide more comprehensive support by allowing persons on public assistance to opt-in to being contacted by charitable organizations.

Recommendation: Request federal Medicaid funds in the form of a block grant.

State Consumer-Directed Health Plan

Recommendation: Allow eligible participants of the group benefits program under the Texas Employees Group Benefits Act to enroll in health savings accounts (HSAs).

Telemedicine

Recommendation: Encourage pay parity for phone consultations by allowing a physician to charge for a telephone consultation with a covered patient if an employee benefit plan or health insurance policy allows any other person to charge for telephone consultations with covered patients.

Supporting the Medical Profession

Recommendation: Increase the number of residency positions available in Texas for medical school graduates.

Background of Recommendations

The objective of Healthy Texans is to improve access to quality care by making strategic improvements to the vast network of doctors, hospitals, and clinics, both public and private.

Taxpayer-funded support for the state's safety net for poor and low-income Texans is generous and extensive. Health and Human Services (HHS) is the second largest government function after public and higher education, with All Funds appropriations (state and federal dollars) for the 2014-15 budget totaling $73.9 billion, or 36.9 percent of all state appropriations.[1] Five agencies, including the Texas Health and Human Services Commission (HHSC), form the HHS system.[2] Spending on the state's Medicaid program constitutes more than three quarters, or $56.2 billion, of HHS appropriations.

Along with HHSC, more than 50 state agencies and higher education institutions spend more than $30 billion annually on direct healthcare services, such as Medicaid for the poor, disabled, and elderly; mental health services; medical benefits for state employees and retirees; and healthcare for prisoners.[3] The state provides health insurance to 4.2 million Medicaid recipients (3.1 million children) and 400,000 Children's Health Insurance Program (CHIP) enrollees, and cash grants to approximately 100,000 Temporary Assistance for Needy Families (TANF) clients.[4] Last session, the Texas Legislature authorized $240 million dollars for women's health—an increase of $113 million over the previous biennium—which is expected to serve 170,000 women, providing them with cancer screening, wellness exams, and other health services.

All Funds appropriations for State Supported Living Centers, which "provide campus-based direct services and supports to people with intellectual and developmental disabilities,"[5] were approximately $1.3 billion in 2014-15, and lawmakers invested $263.4 million ($312.4 million All Funds) to expand mental health services. As of 2010, the Comptroller's Office reported there were 129 hospital districts with independent taxing authority.[6] Hospital districts are countywide and provide hospital care and medical aid to indigent individuals within the district.[7]

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[1] "Fiscal Size Up 2014-2015 Biennium," *Legislative Budget Board*, Feb 2014. http://www.lbb.state.tx.us/Documents/Publications/Fiscal_SizeUp/Fiscal_SizeUp_2014-15.pdf

[2] The remaining four include: Department of Aging and Disability Services (DADS), Department of State Health Services (DSHS), Department of Assistive and Rehabilitative Services (DARS), and Department of Family and Protective Services (DFPS)

[3] "Health Care Costs in Texas," *Texas Comptroller of Public Accounts*. http://thetexaseconomy.org/healthcare/costs/articles/article.php?name=healthcare

[4] "Fiscal Size Up 2014-2015 Biennium," *Legislative Budget Board*, Feb 2014. http://www.lbb.state.tx.us/Documents/Publications/Fiscal_SizeUp/Fiscal_SizeUp_2014-15.pdf

[5] "About State Supported Living Centers," DADS. http://www.dads.state.tx.us/services/sslc/

[6] "Your Money and the Taxing Facts," *Texas Comptroller of Public Accounts*, Aug 2012. http://www.texastransparency.org/Special_Features/Reports/pdf/TexasItsYourMoney-TaxingFacts.pdf

[7] Texas Health and Safety Code §281.002

Texas is also served by a robust network of Federally Qualified Health Centers (FQHCs), organizations that receive grants under the Public Health Service Act and qualify for enhanced reimbursement from Medicare and Medicaid.[8] FQHCs are required to offer a sliding fee scale, provide comprehensive services, and serve an underserved area or population.[9] Services are provided to Medicare, Medicaid, CHIP, insured, and uninsured individuals who may be eligible for services based on their family income and on a sliding fee schedule.[10] There are 70 FQHCs in Texas operating more than 300 sites.[11]

Over the last six biennia, HHS spending has grown by 68.7 percent.[12] While approximately half of the increase in spending may be attributed to factors such as population growth and inflation, after adjusting for these factors, All Funds spending levels for healthcare increased by 34.6 percent and General Revenue Funds increased by 33.7 percent, or an average biennial increase of 6 percent.[13] Looking ahead to the next budget cycle, the five HHS system agencies have requested a total of $83.8 billion All Funds for the 2016-17 biennium, an increase of $8.1 billion over the 2014-15 biennium. This increase, if approved, will amount to an 11 percent increase over the preceding biennium, nearly twice the annual biennial increase experienced over the last decade.

Given the extensive and expensive system of taxpayer-supported healthcare in Texas, it is essential that policymakers build on the best network of healthcare services to enhance access to quality care that focuses on prevention, early detection, and immediate treatment to improve health outcomes and hold down long-term costs as much as possible.

[8] "What are Federally Qualified Health Centers," U.S. Department of Health and Human Services. http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html
[9] *Id.*
[10] "Texas Primary Care Office - Federally Qualified Health Centers," Texas Department of State Health Services, Nov 8, 2013. https://www.dshs.state.tx.us/chpr/fqhcmain.shtm
[11] *Id.*
[12] "Fiscal Size Up 2014-2014 Biennium" Texas Legislative Budget Board, Feb 2014. http://www.lbb.state.tx.us/Documents/Publications/Fiscal_SizeUp/Fiscal_SizeUp_2014-15.pdf
[13] *Id.*

Women's Health

Recommendation: Add optional screening and treatment for postpartum depression to the types of services covered by CHIP Perinatal and Medicaid for low-income pregnant women.

Depression is the leading cause of disability among women in the U.S., accounting for $30 billion to $50 billion in lost productivity and direct medical costs annually.[14] Postpartum depression refers to moderate to severe depression a woman experiences after giving birth.[15] In a CDC survey, 8 to 19 percent of women reported having frequent postpartum depressive symptoms.[16] When undetected or left untreated, symptoms of postpartum depression can persist for many months or even years.[17]

While there is no single cause of postpartum depression, physical changes after childbirth, emotional factors, and lifestyle changes can all contribute to the onset of postpartum depression.[18] Women also have a higher risk of developing postpartum depression if they:[19]

- Have a history of depression;
- Experienced postpartum depression after a previous pregnancy;
- Have experienced stressful events during the past year, such as pregnancy complications, illness, or job loss;
- Are having problems in their relationship with their spouse or significant other;
- Have a weak support system;
- Have financial problems.

[14] "Screening for Depression During and After Pregnancy," *The American College of Obstetricians and Gynecologists*, Feb 2010. https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Depression-During-and-After-Pregnancy

[15] "Depression Among Women of Reproductive Age," Centers for Disease Control and Prevention, Nov 13, 2013. http://www.cdc.gov/reproductivehealth/Depression/

[16] *Id*.

[17] "Postpartum Depression - Symptoms," Mayo Clinic Staff. http://www.mayoclinic.com/health/postpartum-depression/DS00546/DSECTION=symptoms

[18] "Postpartum Depression - Causes," *Mayo Clinic Staff.* http://www.mayoclinic.com/health/postpartum-depression/DS00546/DSECTION=causes

[19] "Postpartum Depression - Risk Factors," *Mayo Clinic Staff*. http://www.mayoclinic.com/health/postpartum-depression/DS00546/DSECTION=risk-factors

Many of the risk indicators listed above are more prevalent among women at the lower end of the socioeconomic spectrum, meaning women eligible for services through the state's women's health programs may be at a higher risk of experiencing symptoms of postpartum depression.[20] In Texas, pregnant women may be eligible for perinatal coverage through CHIP. Women enrolled in CHIP Perinatal are covered for two postpartum doctor visits within the first 60 days of giving birth.[21] CHIP Perinatal does not cover mental health treatment for the mother.[22] Medicaid covers low-income pregnant women for pregnancy-related services for up to 60 days after the last day of the pregnancy.[23]

	Maximum Monthly Income Limit for Medicaid for Pregnant Women[24]	**Maximum Monthly Income Limit for CHIP Perinatal[25]**
Family Size	Income Limit	Income Limit
1	$1,772	$2,014
2	$2,392	$2,714
3	$3,011	$3,416
4	$3,631	$4,115
5	$4,251	$4,815
6	$4,871	$5,517
7	$5,490	$6,216
8	$6,110	$6,916
For each additional person, add:	$620	$702

[20] "Sociodemographic predictors of antenatal and postpartum depressive symptoms among women in a medical group practice," Rich-Edwards, *Journal of Epidemiology and Community Health*, March 2006. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2465548/

[21] "Model Application Template for State Child Health Plan Under Title XXI of the Social Security Act State Children's Health Insurance Program," *Texas Health and Human Services Commission,* March 1, 2012. http://www.hhsc.state.tx.us/medicaid/about/state-plan/docs/CHIPStatePlan.pdf

[22] "CHIP Perinatal Benefits," HHSC. http://chipmedicaid.org/content/chip-perinatal-benefits

[23] "Texas Medicaid and CHIP in Perspective: Ninth Edition - January 2013, Chapter 5: Medicaid Clients," HHSC, Jan 2013. http://www.hhsc.state.tx.us/medicaid/about/PB/6_PB%209th_ed_Chapter5.pdf

[24] "Medicaid for low-income pregnant women," HHSC. http://yourtexasbenefits.hhsc.state.tx.us/programs/health/women/pregnant.php

[25] "CHIP Perinatal Benefits," HHSC. http://chipmedicaid.org/content/chip-perinatal-benefits

	2008	2009	2014 (expected)	2015 (expected)
Average Pregnant Women Medicaid Recipient Months Per Month	125,830[26]	127,461[27]	129,465	130,560
Average CHIP Perinatal Recipient Months Per Month	65,817	69,316	36,895	36,896
Total	191,647	196,777	166,360	167,456

Symptoms of depression can manifest anytime during pregnancy or within the first year of giving birth.[28] Infants of depressed mothers exhibit delayed psychological, cognitive, neurological, and motor development.[29] Pregnancy and the postpartum period present unique opportunities for screening, diagnosing, and treating depression due to the consistent contact women have with the healthcare delivery system during this time. Diagnosing and treating symptoms of postpartum depression benefits both the mother and her family; children's mental and behavioral disorders improve when maternal depression is in remission.[30]

If left untreated, symptoms of postpartum depression may last for months or years, jeopardizing the health and safety of the mother and her child.[31] In 2001, Clear Lake mother Andrea Yates drowned her five children while suffering from a rare disorder called postpartum psychosis. In the aftermath of this tragedy, lawmakers passed a bill requiring healthcare providers who provide prenatal care to a pregnant woman to give her a list of resources that provide postpartum counseling and assistance to parents.[32] The Yates case, and laws passed in its aftermath, raised awareness of postpartum depression, but more needs to be done to ensure new moms have access to screening and care.

[26] http://www.hhsc.state.tx.us/research/MedicaidEnrollment/me-results.asp
[27] *Id.*
[28] "Depression During Pregnancy & Postpartum," *Postpartum Support International.* http://www.postpartum.net/Get-the-Facts/Depression-During-Pregnancy-Postpartum.aspx
[29] "Screening for Depression During and After Pregnancy," *The American College of Obstetricians and Gynecologists*, Feb 2010. https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Depression-During-and-After-Pregnancy
[30] *Id.*
[31] "Postpartum Depression," *Medline Plus,* Aug 15, 2014. http://www.nlm.nih.gov/medlineplus/ency/article/007215.htm
[32] House Bill 341 (78R)

The state plans to spend a portion of the increased funding approved during the 83rd Legislative Session for women's health providing wraparound benefits, such as prenatal and dental care for pregnant women, that are not covered by other public health programs.[33] Lawmakers should also consider expanding benefits under CHIP Perinatal and Medicaid for Pregnant Women to cover screening, diagnosis, and treatment for postpartum depression. As a starting point, the coverage period for postpartum doctor visits for the mother under CHIP Perinatal should be extended from 60 days to up to one year. A woman who reports having symptoms of postpartum depression to her postnatal care provider will be screened for postpartum depression and may be referred to a mental healthcare provider that accepts Medicaid for diagnosis and treatment.

When properly treated, most women respond well and show signs of recovery within six to eight weeks.[34] However, in some cases symptoms might persist past the additional ten-month period. In these instances, patients should be referred to a FQHC where they can continue receiving treatment for depression.

Multiple postpartum depression screening tools exist, including the Edinburgh Postnatal Depression Scale and Postpartum Depression Screening Scale, and most can be completed within 10 minutes.[35] In the event a woman receiving coverage through Medicaid or CHIP Perinatal screens positive for signs of postpartum depression, she would be eligible for mental health services through Medicaid or through one of the state's public health programs. Legislation passed in 2005 required HHSC to conduct a study on the feasibility of providing 12 months of health services under Medicaid to women who are diagnosed with postpartum depression and who are eligible for medical assistance at the time of the diagnosis.[36] The study found that the cost of providing a benefit package limited to mental health services for 10 months following the current 60 day period would cost an estimated $426,742 in general revenue, assuming implementation in Fiscal Year 2008. Programming start-up costs were estimated to be $1.7 million (All Funds).[37] Adjusting for inflation and enrollment growth, the expected cost of implementing such a program in 2016 would be $2 million initially and approximately $500,000 annually for a total cost of $3 million in the 2016-17 biennium.

[33] "New Abortion Limits, but More Money for Women's Health," Becca Aaronson, *The Texas Tribune*, Aug 9, 2013. http://www.texastribune.org/2013/08/09/texas-policies-alter-future-womens-health-services/

[34] "Frequently Asked Questions," *State of New Jersey Department of Health*, Jul 12, 2012. http://www.state.nj.us/health/fhs/postpartumdepression/faq1.shtml#q6

[35] "Screening for Depression During and After Pregnancy," *The American College of Obstetricians and Gynecologists*, Feb 2010. https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Depression-During-and-After-Pregnancy

[36] Senate Bill 826 (79R)

[37] "Postpartum Depression Study," HHSC, Nov 2006. http://www.docstoc.com/docs/59893643/Depression-Study-Pursuant

Recommendation: Increase funding for Texas women's health programs to expand the types of services covered for eligible women enrolled in the program.

The state operates three programs that provide preventive healthcare to women: the Texas Women's Health Program (operated by HHSC), Department of State Health Services (DSHS) Family Planning Services, and Expanded Primary Health Care (operated by DSHS). For the 2014-15 biennium, lawmakers authorized $240 million to fund women's health[38]—a $113 million increase over the previous biennium. Currently the Texas Sunset Advisory Commission is considering measures to consolidate and streamline the state's health programs for women to promote better access among eligible clients. In the meantime, there is still much that can be done to bolster the support women receive from the Texas Women's Health Program (TWHP).

TEXAS Health and Human Services Commission

Service Capacity for Women's Health Programs

	FY 2011	FY 2015
Texas Women's Health* *(115,226 served in FY2011)*	Clients 127,536 (enrolled)	Clients *(Projected)* 123,083
Family Planning	202,968	65,000
Expanded Primary Health Care	--	170,000
Breast/cervical Cancer Screening	35,911	43,000
Total	366,415	401,083

** The Women's Health Program number is the number of women enrolled in the program. This is the number of women with coverage and access to services, although the number of women who seek services through the program is typically a little lower. For example, In FY2011 the average monthly enrollment in the program was 127,536, and the number of women who received services was 115,226.*

The Texas Women's Health Program (TWHP) serves women between ages 18 and 44 who earn up to 185 percent of the federal poverty level. Since the program focuses on family planning, women who are already pregnant are not eligible. Covered services include pelvic examinations, STD screenings and treatment, HIV screenings, diabetes screenings, high blood pressure screenings, cholesterol screenings, breast and cervical cancer screenings, and contraceptives.

[38] $72.4 million to fund the Texas Women's Health Program; $43.2 million appropriated to DSHS Family Planning; $100 million to DSHS Expanded Primary Health Care (EPCH); $24.5 million to DSHS Breast/cervical Cancer Screening.

All Funds Appropriations for Women's Health Services[39]

	2010-11 Budget	2014-15 Budget
Texas Women's Health Program	$72.3 million[40]	$72.4 million
DSHS Family Planning	$111.2 million	$43.2 million
Expanded Primary Health Care	N/A	$100 million
Breast/cervical Cancer Screening	$17.9 million	$24.5 million
Total	$201.4 million	$240.1 million

Source: Texas Health and Human Services Commission

Prior to 2012, the TWHP was administered as part of the state's Medicaid program and was called the Women's Health Program (WHP). In 2012, the federal government denied the state's Medicaid waiver—effectively cutting off funding—for the Women's Health Program. As a Medicaid program, the Women's Health Program had been receiving a nine-to-one match in federal funding. To prevent a lapse in coverage for women's health services, the program was renamed the Texas Women's Health Program, which is now exclusively funded through General Revenue. Women who had been enrolled under the WHP Medicaid program were required to re-enroll in the new program.

Today, the TWHP network of health service providers is comprised of 3,853 certified providers—more than under the Medicaid program. The TWHP also offers an expanded package of covered services compared to the WHP.

City	Number of TWHP Providers within 30 miles
San Angelo	39
Tyler	93
Abilene	19
McAllen	187
Amarillo	35

Source: Texas Women's Health Program

[39] "Presentation to Senate Committee on Health and Human Services: Texas Women's Health and Family Planning Programs," *Texas Health and Human Services Commission & Texas Department of State Health Services*, Feb 20, 2014. http://www.hhsc.state.tx.us/news/presentations/2014/022014-womens-health.pdf

[40] Amount in 2010-2011 includes federal funding (approximately 9:1 match)

Texas women's health programs are, combined, currently being funded at an all-time high level, and a provider network is in place with the capacity to serve more than 170,000 women. The Texas Women's Health program received $72.4 million in appropriations for the 2014-15 biennium, compared to $69.2 million in the previous biennium.

The 84th Legislature should consider increasing funding for Texas women's health programs by $50 million and direct that HHSC use the increased appropriation to expand TWHP's services to cover follow-up screenings for women with abnormal breast or cervical cancer test results or cervical dysplasia treatment, and offer individualized case management. HHSC should also continue to actively market the Texas Women's Health Program to ensure women are aware that they may be eligible to enroll.

Services for Survivors of Sexual Assault and Abuse

Recommendation: Increase appropriations to the Office of the Attorney General to increase by 100 the number of newly-certified Sexual Assault Nurse Examiners (SANEs) who are trained each year to provide an improved level of care and compassion for victims, along with careful evidence collection and the expertise needed for effective prosecution.

For survivors of sexual assault, the hours immediately following the attack are among the most traumatic. A Sexual Assault Nurse Examiner, or SANE as they are commonly called, is a registered nurse who has been trained to (1) provide comprehensive care to sexual assault patients; (2) conduct a medical forensic exam and evaluation for evidence collection; (3) possess the expertise required to provide effective courtroom testimony; and (4) display compassion and sensitivity to sexual assault survivors.[41] As a result of their training, SANEs are capable of providing survivors of sexual assault with a superior level of treatment and care that is vital to victims' recoveries. SANEs also ensure evidence is collected properly, thereby playing a critical role in the prosecution of sexual assault crimes.

Even if a victim has not yet decided whether to report an incident of sexual assault to law enforcement, the first thing all survivors should do is obtain a medical forensic exam for the purpose of evaluation and treatment of trauma and possible infection, counseling referrals, and the collection of evidence.[42] Hospitals are often the starting point of the victim's road to recovery, as well as their initial contact point with the criminal justice system. Survivors who receive proper treatment from trained sexual assault examiners recover from the physical and mental trauma of an assault more quickly and are more likely to follow through and participate in the prosecution of criminal cases.[43]

[41] "Sexual Assault Nurse Examiner Program: Frequently Asked Questions," *Office of the Texas Attorney General,* March 31, 2011. https://www.oag.state.tx.us/victims/sane.shtml
[42] *Id*.
[43] *Id*.

Dallas' first SANE program launched in 2010, and within four months, reporting for sexual assaults in Dallas County rose by 25 percent.[44] As hospitals have become increasingly aware of the important role they play in the prosecution of sexual assault cases, more and more have implemented Sexual Assault Nurse Examiner programs designed to provide comprehensive and compassionate care to survivors.[45]

Despite increased awareness of the benefits derived from SANE programs, start-up costs can frustrate efforts to launch additional SANE programs in new communities. The average start-up costs for a new SANE program are reported to run between $30,000 and $40,000.[46] At the same time, SANE nurses can conduct a forensic medical exam more efficiently than a hospital physician, and their hourly rates are much lower, leading to future cost savings for hospitals that train and employ SANE nurses.[47]

The Office of the Attorney General (OAG), through the Sexual Assault Prevention and Crisis Services, a program of the Crime Victim Services Division that certifies SANEs, will be requesting proposals from hospitals for participation in a pilot program to provide funding for training and certification of SANEs. The program will endeavor to identify qualified instructors to train SANE nurse candidates in evidence collection and testifying in court. Pilot programs such as this one are useful for assessing the demand for SANE training. Nationally, SANE training per person costs between $250 for basic training to $1,200 for a week of advanced clinical training.[48] Lawmakers in the upcoming session should examine the results of the OAG program and appropriate $500,000 to support SANE start-up costs—which can include needs assessments, facilities and equipment, staff advertising and selection, and media promotion—as well as training and certification for an additional 100 SANE nurses each year. Additionally, lawmakers should work with the state's higher education nursing programs to encourage the creation of more SANE specialty slots.

[44] "Sexual Assault Nurse Examiner Program," *Texas Health Resources*. http://www.texashealth.org/dallassane
[45] *Id*.
[46] "SANE Development and Operation Guide," Office for Victims of Crime, U.S. Department of Justice. https://www.ncjrs.gov/ovc_archives/reports/saneguide.pdf
[47] *Id.*
[48] *Id.*

Recommendation: To provide more services and greater protection for victims of domestic abuse, create Domestic Violence High Risk Teams, which unite law enforcement, medical professionals and victim advocates at the local level to review cases of domestic violence, and identify, monitor, and contain the most dangerous perpetrators before they can inflict deadly harm.

In 2012, there were 198,366 family violence incidents in Texas, up 11.5 percent from 2011.[49] In 2012 alone, domestic, or family violence, took the lives of 114 women in Texas, 12 more fatalities than occurred in 2011.[50] Research suggests that survivors of domestic violence often suffer long-term health consequences.[51] One survey found that women who identified themselves as survivors of domestic abuse were 20 percent more likely to experience a chronic health condition than women who have never suffered abuse.[52] Survivors of abuse also reported up to twice as many chronic health conditions compared to women who said they had never been abused. It follows that preventing domestic abuse has a lasting impact on a woman's health.

Research by the nation's leading expert on domestic violence suggests that the single biggest indicator for domestic homicide is a prior incidence of physical domestic violence.[53] The Jeanne Geiger Crisis Center (JGCC) in Newburyport, Massachusetts developed the Domestic Violence High Risk Team Network, an innovative, nationally recognized tool for preventing domestic violence by performing risk assessments used to predict when a violent or lethal incident is likely to occur. The assessments evaluate the batterer's history and behavioral patterns, allowing law enforcement and victim services providers to view distinct acts of violence in context. Analyzing lethality factors and violent behavior patterns enables a high-risk team to intervene in order to prevent homicides and re-assaults.[54]

[49] "Family Violence," Texas Crime Report for 2012. http://www.dps.texas.gov/crimereports/12/citCh5.pdf
[50] "Honoring Texas Victims: Family Violence Fatalities 2012," Texas Council on Family Violence. http://www.tcfv.org/wp-content/uploads/2013/10/HonoringTexasVictims_FullReport_8.5X11.pdf
[51] "Domestic Abuse has Long Term Health Impact, Survey Says," Liz Neporent, *ABC News*, Nov 5, 2013. http://abcnews.go.com/Health/domestic-abuse-long-term-health-impact-survey/story?id=20778233&singlePage=true
[52] *Id.*
[53] "A Raised Hand," Rachel Louise Snyder, The New Yorker, July 22, 2013, p. 34.
[54] "Working to Predict and Prevent Domestic Violence," Suzanne Dubus, Champions of Change, November 2, 2011. http://www.whitehouse.gov/blog/2011/11/02/working-predict-and-prevent-domestic-violence

The Domestic Violence High Risk Team (DVHRT) consists of multi-disciplinary teams that coordinate efforts to increase victim safety by monitoring and containing perpetrators while providing victim services.[55] Risk assessments allow team members to put individual incidents of violence in context and form the basis for individualized intervention plans. Teams unite police, prosecutors, victim-witness advocates, probation officials, batterers' intervention teams, and hospital staff in order to create a vehicle for communication among disciplines to provide the best possible responses to victims at high-risk. In the JGCC high-risk team's first eight years, 92 percent of survivors have reported that there have been no re-assaults.[56] The DVHRT model has been replicated in 21 communities in Massachusetts and several others across the country.[57] In its first six years, the JGCC team has handled 106 high-risk cases (Less than five percent of cases score in this bracket; for those that do, an intervention plan is immediately put into place.) and experienced zero homicides.

The first step to implementing a network of Domestic Violence High Risk Teams in Texas is the creation of a new $2 million annual grant program under the purview of the Office of the Attorney General.[58] Implementing a DVHRT model in Texas can be achieved using existing resources of the various agencies and entities involved. Additional funding for the new program could come from federal grants solely dedicated for the prevention of family violence. For example, in the 2013 fiscal year, Congress appropriated $409 million for Violence Against Women Act (VAWA) programs.[59] Texas is eligible for a portion of this funding, having received $14.7 million in 2010-11 and $16 million in 2012-13. These funds were used to "develop and strengthen effective criminal justice strategies and victim services programs to combat violent crimes against women."[60] Federal law requires that certain amounts of these grants be used directly for prosecution, law enforcement, victim services, and court costs, but "the remainder of the funds may be spent at the discretion of the state… to provide personnel, training, technical assistance, data collection, and equipment for apprehension, prosecution, and adjudication of persons committing violent crimes against women."[61] Grant resources would be awarded to law enforcement and local nonprofits that will take the lead in forming domestic violence high-risk teams to respond to domestic violence in their respective communities.

[55] Domestic Violence High Risk Team Network, Jeanne Geiger Crisis Center. http://www.jeannegeigercrisiscenter.org/dvhrtn.html?pg=01
[56] http://jeannegeigercrisiscenter.org/dvhrtn.html?pg=04
[57] "Making An Impact By Preventing Domestic Violence Homicide," Domestic Violence High Risk Team Network, Jeanne Geiger Crisis Center. http://jeannegeigercrisiscenter.org/dvhrtn.html?pg=04
[58] The Jeanne Geiger Crisis Center's weekly operating budget is $38,000 ($1,976,000 annually).
[59] "Cardin, Mikulski Announce $1 Million Grant To Protect High Risk Victims of Domestic Violence," March 28, 2013. http://www.cardin.senate.gov/newsroom/press/release/cardin-mikulski-announce-1-million-grant-to-protect-high-risk-victims-of-domestic-violence-
[60] Legislative Budget Board, Fiscal Size-Up, 2010-11 and 2012-13.
[61] Legislative Budget Board, "Top 100 Federal Funding Sources in the Texas State Budget," February 2013.

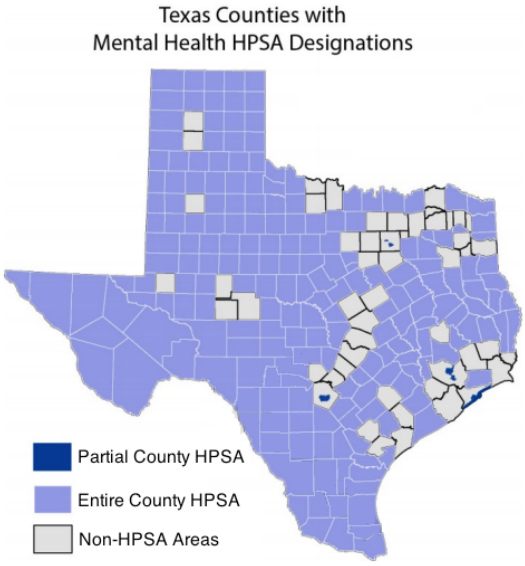
Mental and Behavioral Health Care

Recommendation: Extend loan forgiveness programs to mental health professionals who practice in underserved areas.

It is estimated that 20 percent of Texas adults are living with a mental illness, and four percent are considered serious conditions.[62] Approximately 300,000 children in the state are suffering with a serious mental health condition.[63] Rural areas are particularly underserved.

There are some incentives in place to entice doctors to work in underserved areas. The National Health Service Corps (NHSC) "provides financial incentives to students and clinicians in exchange for practicing at approved NHSC sites located in Health Professional Shortage Areas (HPSAs)."[64] This includes licensed primary care medical, dental, mental, and behavioral health providers.[65] Texas incentivizes certain practitioners in underserved areas by providing loan forgiveness of up to $160,000 over four years through the Physician Education Loan Repayment Program (PELRP).[66] The program is open to doctors of family medicine, internal medicine, pediatrics, OB/GYN, geriatrics, and psychiatry.[67] Recipients of PELRP must work in designated underserved areas, must accept Medicaid (and CHIP if the practice includes children), and cannot refuse a patient for their inability to pay.[68] The Texas Medical Association calls the PELRP "a critical recruitment tool," and "one of the most successful models to address the state's physician shortage."[69]

[62] "Scope of the Problem," Texas Hospital Association.
www.tha.org/HealthCareProviders/Issues/BehavioralMentalHea096F/FacingBehavioralHea094D/ScopeoftheProblem/index.asp
[63] *Id.*
[64] "Texas Primary Care Office Information," *Texas Department of State Health Services,* Aug 20, 2013.
https://www.dshs.state.tx.us/chpr/tpco_info.shtm
[65] The NHSC Loan Repayment Program, National Health Services Corps.
https://nhsc.hrsa.gov/loanrepayment/nhscloanrepayment/index.html
[66] Physician Education Loan Repayment Program, Texas Higher Education Coordinating Board.
http://www.hhloans.com/index.cfm?ObjectID=A85AA8AA-0CD1-EDD4-D9379C7C084059FB
[67] *Id.*
[68] "The Physician Education Loan Repayment Program," Legislative Budget Board Issue Brief, Apr 2013.
http://www.lbb.state.tx.us/Documents/Publications/Issue_Briefs/463_Pelrp.pdf
[69] "Physician Loan Repayment Program: A Critical Recruitment Tool," Texas Medical Association.
http://www.texmed.org/Template.aspx?id=7276



Texas has 375 federally recognized HPSAs, the second highest in the nation, with 71.06 percent of the need met.[70] These areas have a population-to-primary care physician ratio of at least 3,500 to one[71] and are lacking practitioners geographically and in certain population groups, and also lack facilities.[72] The shortage of mental health services, however, is more dire. Texas has 333 HPSA designations for mental health (called MHPSAs), and only 46.75 percent of the need is met.[73] To remove that designation, the state will require at least 193 practitioners in these areas.[74] (See graphic)[75]

The state should revise and extend the Physician Education Loan Repayment Program to mental health professionals who provide direct care services as employees of mental health authorities, public hospitals, and clinics in underserved areas, and not simply limit the program to psychiatrists. This could include licensed professional counselors, licensed clinical social workers, and licensed psychologists. Eligibility requirements similar to the requirements for PELRP would apply, with some adjustments regarding licensing, degrees, and time served:

- Hold the appropriate license from the state (Texas State Board of Examiners of Professional Counselors, Texas State Board of Social Worker Examiners, Texas State Board of Examiners of Psychologists);
- Hold a degree from an accredited Texas institution of postsecondary higher education, public or private;
- Be eligible to take the exam for board certification from specialty boards established in the Texas Higher Education Coordinating Board administrative rules if the individual has not earned and maintained board certification;
- Agree to provide five consecutive years of service in a (1) federally designated Health Professional Shortage Area, (2) secure correctional facility operated by or under contract with the Texas Juvenile Justice Department, or (3) secure correctional facility operated by or under contract with the Texas Department of Criminal Justice;

[70] Mental Health Care Health Professional Shortage Areas (HPSAs), Kaiser Family Foundation. http://kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/
[71] Underserved Areas of Texas, Texas Medical Association.http://www.texmed.org/Template.aspx?id=2348
[72] Mental Health HPSA Designation Overview, Health Resources and Services Administration. http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsaoverview.html
[73] Kaiser Family Foundation, *supra*.
[74] *Id.*
[75] "2013 Mental Health Workforce Shortage Report (August Draft)," DSHSHealth Professions Resource Center, Sept 2014. https://www.dshs.state.tx.us/chs/hprc/

- Provide direct patient care to Medicaid enrollees and CHIP enrollees if the practice includes children;
- Not be currently fulfilling another obligation to provide medical services as part of a scholarship agreement, a student loan agreement, or another student loan repayment program.[76]

Licensed professional counselors are mental health professionals with master's degrees who are licensed by the state.[77] Professional counseling is defined as "the application of mental health, psychotherapeutic, and human development principles to facilitate human development and adjustment…" along with prevention, assessment, and evaluation.[78] Licensed clinical social workers must have obtained a master's degree with a Council of Social Work Education accreditation or a doctorate in a social work program[79] and are authorized "in the areas of assessment, diagnosis, and treatment of mental, emotional, and behavioral disorders, conditions and addictions, including severe mental illness in adults and serious emotional disturbances in children."[80] Psychologists have obtained a doctorate-level degree[81] and "diagnose and treat mental, nervous, emotional, and behavioral disorders and ailments."[82]

The state should provide additional spots for PELRP recipients, reserved for these mental healthcare professionals. As a starting point, an additional 20 spots would cost, at the most, approximately $1.2 million for the first biennium. As the PELRP receives the majority of its funding from the smokeless tobacco tax,[83] the additional costs could be funded the same way.

Recommendation: Offer designated mental and behavioral health screening days for veterans and service members near military installations.

The services in this recommendation are available to the approximately 1.6 million veterans,[84] 131,584 active duty military, and 56,367 Reserve soldiers and National Guard members[85] who reside in Texas.

[76] "PELRP Fact Sheet Feb. 2014," HH Loans, Texas Higher Education Coordination Board. http://www.hhloans.com/index.cfm?ObjectID=A85AA8AA-0CD1-EDD4-D9379C7C084059FB
[77] "Who Are Licensed Professional Counselors," American Counseling Association, 2011. https://www.counseling.org/PublicPolicy/WhoAreLPCs.pdf
[78] Texas State Board of Examiners of Professional Counselors About the Profession - Scope of Practice, DSHS. https://www.dshs.state.tx.us/counselor/lpc_scope.shtm
[79] Texas Social Work Licensure Requirements, SocialWorkLicensure.org. http://www.socialworklicensure.org/state/social-work-licensure-texas.html
[80] "The Supply of Mental Health Professionals in Tarrant County - 2005," DSHS Center for Health Statistics, Health Professionals Resource Center, Jul 2007. http://www.mentalhealthconnection.org/pdfs/workforce-update.pdf
[81] "What are the qualifications to become licensed as a psychologist in the U.S.?" American Psychological Association. http://www.apa.org/support/careers/licensure/qualifications.aspx#answer
[82] DSHS Center for Health Statistics, Health Professionals Resource Center, *supra*.
[83] Legislative Budget Board, Apr 2013, *supra*.
[84] "Veteran Population," Veterans Administration. http://www.va.gov/vetdata/Veteran_Population.asp
[85] "Military and Civilian Personnel in Installations: 2009," Census.gov. http://www.census.gov/compendia/statab/2012/tables/12s0508.pdf

In the general population, seven to eight percent of Americans suffer from post-traumatic stress disorder (PTSD). In the military population, experts believe that 11-20 percent of veterans of the wars in Iraq and Afghanistan, ten percent of Gulf War veterans, and 30 percent of Vietnam veterans suffer from PTSD.[86] Only half of service members returning from the wars in Iraq and Afghanistan have sought treatment.[87] For those who do seek help for PTSD or major depression, only half receive what researchers call "minimally adequate" treatment.[88] According to the Armed Forces Health Surveillance Center, "[m]ental disorders are the leading cause of hospital bed days and the second leading cause of medical encounters for active component service members in the U.S. military," and that number increased by 87 percent from 2000 to 2011.[89]

Suicide risk is a particular concern for veterans. Though veterans comprise only 10 percent of the population, they account for 20 percent of suicides.[90] Fortunately, utilizing proven methods of treating mental health issues means lessening suicide risk; a study conducted by the Millennium Cohort Study found that mental health and substance abuse issues were significantly related to suicide risk, while combat or deployment experience was not.[91]

Problematically, many service members fear they will be penalized or their careers will be stalled if they seek mental health treatment through their post or base. One Navy Commander notes, "[m]any service members fear that seeing a psychologist will sink their careers… They worry—often needlessly—that their problems will get back to their bosses, endanger their security clearances and even result in their separation from the service."[92] The military has put forth several major efforts over many years in attempting to remove the stigma and treat trauma.[93]

Even if a veteran or service member wants to seek treatment, the backlog at their local Veterans Administration (VA) may prevent timely care. The VA has, for many years, been criticized for a lengthy backlog in cases. In March 2013, the VA waitlist reached 600,000, with 900,000 total claims pending.[94]

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[86] http://www.ptsd.va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp and http://www.ptsd.va.gov/professional/PTSD-overview/epidemiological-facts-ptsd.asp

[87] "One In Five Iraq and Afghanistan Veterans Suffer from PTSD or Major Depression," RAND, Apr 17, 2008. http://www.rand.org/news/press/2008/04/17.html

[88] *Id.*

[89] "Medical Surveillance Monthly Report," Armed Forces Health Surveillance Center, July 2013. http://www.afhsc.mil/viewMSMR?file=2013/v20_n07.pdf

[90] "Veterans' access to mental health services needs fixing," Ret. Lt. Col. Steve Brozak, *CNN Money,* Nov 11, 2013. http://money.cnn.com/2013/11/11/news/economy/veterans-mental-health/

[91] "Suicide, Mental Disorders, and the US Military: Time to Focus on Mental Health Service Delivery," Charles C. Engel, MD, MPH, *The Journal of the American Medical Association,* Aug 7, 2013. http://jama.jamanetwork.com/article.aspx?articleid=1724254

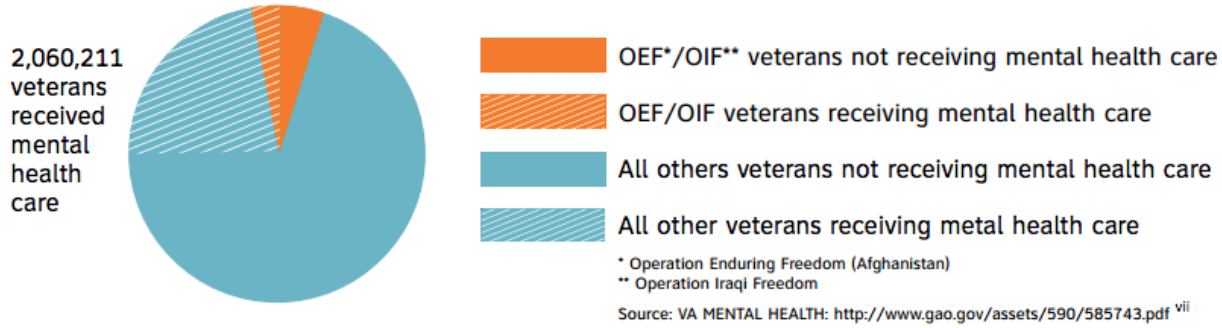
[92] "The military's war on stigma," Sadie F. Dingfelder, *Monitor on Psychology,* June 2009. http://www.apa.org/monitor/2009/06/stigma-war.aspx

[93] "Military Looks to Redefine PTSD, Without Stigma," Larry Abramson, *NPR*, May 14, 2012. http://www.npr.org/2012/05/14/152680944/military-looks-to-redefine-ptsd-without-stigma

[94] "The Battle to End the VA Backlog," Iraq and Afghanistan Veterans of America (IAVA) Issue Report, http://iava.org/battle-end-va-backlog

The VA was recently caught in a scandal when it was revealed that many VA clinics were falsifying paperwork related to wait times for veterans requesting an appointment, so as to make it appear that there was little backlog.[95] This scandal included the Austin Outpatient Clinic.[96] Though Congress took action to correct the issue, the VA is still making errors in addressing the backlog.[97] In a survey conducted by Iraq and Afghanistan Veterans of America of their members, 80 percent of respondents felt that the Department of Defense and VA were not providing adequate support for mental health injuries and issues.[98] Only 29 percent of veterans who received care from the VA also received mental healthcare.[99]

Veterans who Received Mental Health Care from the VA Veterans Health Administration, 2006-2010



Source: NAMI[100]

So that veterans and service members can receive a diagnosis and move forward with treatment, the state should partner with qualified providers who are established nearest to the major military installations in Texas—Fort Hood, Fort Bliss, and those in San Antonio—to provide designated mental health screening days for veterans and service members After completion of a screening, the individuals can take the next necessary steps to seek treatment based on their referral.

[95] "How the VA developed its culture of coverups," David A. Farenthold, *The Washington Post*, May 30, 2014. http://www.washingtonpost.com/sf/national/2014/05/30/how-the-va-developed-its-culture-of-coverups/
[96] *Id.*
[97] "VA is making disability payment errors in rush to cut backlog, watchdog says," *FoxNews.com*, Jul 15, 2014. http://www.foxnews.com/politics/2014/07/15/va-is-making-disability-payment-errors-in-rush-to-cut-backlog-watchdog-says/
[98] IAVA Member Survey 2013. http://iava.org/files/2013survey/IAVAMemberSurvey2013.pdf
[99] "Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access," Report to the Ranking Member, Committee on Veterans' Affairs, House of Representatives, United States Government Accountability Office, Oct 2011. http://www.gao.gov/assets/590/585743.pdf
[100] "New Mental Health Coverage for Veterans," National Alliance on Mental Illness (NAMI), Mar 2013. http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Public_Policy/Issue_Spotlights/Health_Care_Reform/ACA-FactSheet7-Veterans.pdf

Several templates exist for such a program. For example, the Department of Defense provides similar in-person screening events.[101] State health agencies also coordinate programs with the military, for instance, Operation Lone Star, a partnership between DSHS, the Texas Military Forces, and local health departments, coordinates vaccinations and free medical care for Texans along the border.[102]

Disability Services

The notion of institutionalization has fallen out of favor as a method of treatment, and the demand for State Supported Living Centers (SSLCs) and other institutions has declined.[103] The 1999 Supreme Court case *Olmstead v. L.C.* required states to "eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs".[104] Community-based services must be accommodated whenever possible, and consumer-directed delivery should be offered as the first option.

The state should work to ensure that people with disabilities, their families, and their caregivers receive the chosen treatment and care for their needs in a way that is consumer-directed. Note below that the Department of Aging and Disability Services waitlist for community care is in fact called an interest list as a way to keep track of the demand for community-based services. Based on this interest list, it is clear there is a strong demand for these services.

Recommendation: In order to recruit and retain personal attendants, and provide home- and community-based living options, increase pay for personal attendants.

Personal attendants, also called direct-support workers or community attendants, help individuals with disabilities with day-to-day tasks. Those may include personal care, bathing, dressing, household chores, errands, and health-related tasks prescribed by a physician. Attendants make it possible for those in need to live at home independently. A person with a disability may have a higher quality of life with this option, and many prefer it to institutional living as they can choose the attendant who best fits their lifestyle.

There are several Department of Aging and Disability Services (DADS) programs that provide home care or community services for those with physical or intellectual disabilities. Many are waitlisted:

[101] Military Pathways (DoD Mental Health Self-Assessment (MHSA) Program), Deployment Health Clinical Center. http://www.pdhealth.mil/militarypathways.asp
[102] "Operation Lone Star Brings Free Medical Care to South Texas," DSHS News Release, Jul 19, 2011. https://www.dshs.state.tx.us/news/releases/20110719.shtm
[103] "Transform State Residential Services for Persons with Intellectual and Developmental Disabilities," Legislative Budget Board Staff, Jan 2011. https://www.disabilityrightstx.org/files/State_Supported_Living_Centers.pdf
[104] "Olmstead: Community Integration for Everyone," ADA. http://www.ada.gov/olmstead/index.htm

DADS June 2014 Interest List Summary [105]

Program	Number Enrolled 2013-2014	Number Still on Interest List	Longest Wait Time on Interest List
Community Based Alternatives (CBA)	1,387	7,072	1 year
Community Living Assistance and Support Services (CLASS)	88	51,080	9-10 years
Home and Community-based Services Program (HCS)	319	71,796	11-12 years

In Texas, it is estimated that the demand for personal attendants and other direct-support workers will grow by 45 percent between 2006 and 2016, and by 2018, home-based direct-support workers are estimated to outnumber facility workers nearly 2-to-1.[106] Personal attendants and home-based care can represent significant cost savings according to the National Council on Disability. In 2009, the average annual per-capita expenditures for large state institutions totaled $196,735, while home- and community-based care cost $43,969.[107]

Despite their necessity, the turnover rate for qualified personal attendants is high, as the work is demanding and the pay is low. Currently, the wage set for personal attendants varies but is usually $7.50 per hour–$0.25 more than the federal minimum. In FY 2013, the five HHS agencies[108] had a turnover rate of 22.9 percent, totaling 13,000 employees, compared to 17.6 percent statewide.[109]

In its 2016-17 Legislative Appropriations Request, HHSC has asked for an additional $7.4 million in General Revenue ($16.6 million All Funds) to support a five percent wage increase for DADS direct care support professionals.[110] HHSC has also requested $97.9 million in General Revenue ($223.5 million All Funds) to increase community attendant care professionals' wages by five percent.[111] The state should support this increase in order to recruit personal attendants so consumers may have a choice in their care and retain workers that meet their needs with whom they feel comfortable.

[105] DADS Interest List Reduction Report Summary Fiscal Years 2014-2015. www.dads.state.tx.us/services/interestlist/index.html
[106] Home and Community-based Services Workforce Advisory Council Final Workforce Recommendations. November 2010.
[107] "Forging Ahead: Developing a Plan and Building Community Capacity," National Council on Disability. http://www.ncd.gov/publications/2012/Sept192012/Plans
[108] The five agencies that comprise the HHS system are: Health and Human Services Commission, Department of Aging and Disabilities Services, Department of State Health Services, Department of Assistive and Rehabilitative Services, and Department of Family and Protective Services
[109] HHSC Exceptional Item Request, Legislative Appropriations Request (84R) Version 1, Aug 18, 2014. http://www.hhsc.state.tx.us/LAR/2016-2017/4A-exceptional-item-request-schedule.pdf
[110] *Id.*
[111] *Id.*

Increasing Accountability of Benefits

Recommendation: Transform social service delivery and provide more comprehensive support by allowing persons on public assistance to opt-in to being contacted by charitable organizations.

According to a 2012 study, "Texans reported charitable contributions totaling more than $10.7-billion in 2008—third in the nation, behind California and New York."[112] At the same time, tens of thousands of Texans receive public benefits every year. For example, 112,431 Texans received TANF benefits in December 2011.[113] The burden on taxpayer resources represented by public assistance programs can be reduced by enabling charitable organizations to directly contact to families in need.

Charitable community- and faith-based organizations are already authorized to participate in a community-based program to assist individuals applying online for public assistance benefits.[114] Public assistance programs, such as TANF, ultimately amount to little more than a financial transaction. By allowing charitable groups to participate, TANF and similar programs are infused with a personal element, affording recipients the opportunity to receive assistance that adopts a comprehensive approach. Charitable organizations focus on improving lives by helping individuals overcome barriers to opportunity to realize their true potential, which ultimately may yield better results by allowing more people to become independent.

Texas should create an option for all Texans on public assistance to opt-in to a program allowing charitable organizations to contact them. The decision to opt-in would not impact the individuals' existing benefits, which they would continue to receive for as long as they remain eligible and enrolled. Requiring an opt-in before such information is released will protect privacy rights and ensure only those Texans who wish to be contacted will have their information released. This mechanism will enable charitable organizations to reach out directly to persons in need and maximize the effectiveness of charitable benefits.

Recommendation: Request federal Medicaid funds in the form of a block grant.

Because Medicaid is an entitlement program and must serve everyone who qualifies and enrolls, its weakness is that it is difficult to cover very different populations with very different needs.[115] Medicaid is in dire need of reform by giving the states more local control in the form of block grants.

[112] "How States Stack Up in Generosity," Chronicle of Philanthropy, August 19, 2012. http://philanthropy.com/article/Sharing-the-Wealth-How-the/133605/
[113] U.S. Department of Health and Human Services. http://www.acf.hhs.gov/programs/ofa/resource/2011-recipient-tan
[114] Tex. Health and Human Services Code §531.752
[115] "It's Time to Remake Medicaid," Stuart M. Butler, Ph.D., *The Heritage Foundation*, June 6, 2012. http://www.heritage.org/research/commentary/2012/06/its-time-to-remake-medicaid

Block grants for Medicaid have been pushed for decades, first by President Ronald Reagan in 1981, then by House Speaker Newt Gingrich in 1995, and by President George W. Bush in 2003.[116] Some efforts have been successful. There are recent examples of the federal government giving effective block grants of Medicaid funds to states, and these generally have led to greater policy innovation and the saving of taxpayer money. For example, in Indiana, a waiver allowed the state to introduce subsidized Health Savings Accounts (HSAs) into its Medicaid program—a popular reform that surveys at a 94 percent satisfaction rate.[117] (Problematically, the Obama Administration denied a request to extend this waiver when it expired in 2012).[118] Similarly, a block grant the George W. Bush Administration approved for Rhode Island saw major success:

> Rhode Island was able to save $100 million, and slow the growth of Medicaid from 8 percent per year to 3 percent, by making a few tweaks to their program that they couldn't before: shifting more Medicaid patients from nursing homes to home- and community-based services; automatically enrolling children with special needs and adults with disabilities into care-management programs; etc.[119]

Medicaid spending already comprises more than one quarter of the state budget.[120] Federal Medicaid rules are overly restrictive and make it difficult to implement innovative plans to reduce costs. The Texas Medicaid Provider Procedures Manual (updated monthly) is currently over 1,800 pages long. Doctors are not only leaving the program for reimbursement reasons, but also because compliance is difficult and convoluted.[121]

[116] "How Medicaid Block Grants Would Work," Mary Agnes Carey and Marilyn Werber Serafini, *Kaiser Health News*, Mar 6, 2011. http://www.kaiserhealthnews.org/stories/2011/march/07/block-grants-medicaid-faq.aspx
[117] "Why Block-Granting Medicaid Will Result in Better Health Care for the Poor," Avik Roy, *Forbes*, September 30, 2013. http://www.forbes.com/sites/aroy/2012/09/30/why-block-granting-medicaid-will-result-in-better-health-care-for-the-poor/
[118] "Obama Administration Denies Waiver for Indiana's Popular Medicaid Program," Avik Roy, *Forbes*, November 11, 2013. http://www.forbes.com/sites/aroy/2011/11/11/obama-administration-denies-waiver-for-indianas-popular-medicaid-reform/
[119] Roy, September 30, 2013, *supra*.
[120] "Fiscal Size Up 2014-2015 Biennium," *Legislative Budget Board*, Feb 2014. http://www.lbb.state.tx.us/Documents/Publications/Fiscal_SizeUp/Fiscal_SizeUp_2014-15.pdf
[121] Texas Medicaid Provider Procedures Manual Volumes 1 and 2, July 2014. http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/TMPPM/2014/TMPPM_July_2014.pdf

Even the waiver process, which allows states to exempt themselves from certain Medicaid provisions and/or receive authorization to implement innovative delivery models for healthcare services, takes years to complete and implement. For instance, in 2011 Texas applied for and received a Medicaid transformation waiver to establish a risk-based incentive pool that would allow regional healthcare providers to utilize billions of dollars in funding over five years for experimental projects aimed at improving health outcomes.[122] Federal approval for more than 1,100 projects under the waiver was not secured until May 2013, and approximately 200 additional projects were not approved until summer of 2014.[123] Many of the approved projects required two years to implement. The time and resources exhausted in administering this five-year demonstration waiver could arguably have been better spent if the state was allowed to operate its Medicaid program without the constant need for approval from the federal Centers for Medicare and Medicaid Services.

Recent experience with block grants demonstrates clearly that states can pioneer new and effective policies and use funds more efficiently if they have more discretion over how to use Medicaid funding, which would be accomplished by the state receiving these funds as a block grant. Texas should request the federal government provide Medicaid funds in the form of a block grant.

State Consumer-Directed Health Plan

Recommendation: Allow eligible participants of the group benefits program under the Texas Employees Group Benefits Act to enroll in health savings accounts (HSAs).

Currently, the group benefits program (GBP) under the Texas Employees Group Benefits Act provides health coverage through a self-funded plan administered by the Employees Retirement System of Texas (ERS) for state employees, retirees, and their dependents.

Creating a consumer-directed health plan (CDHP) option for eligible participants of the current GBP would allow the state to make a contribution for those who select the CDHP equal to the contribution for the basic health plan. This contribution would be split between funding the high-deductible health plan (HDHP) and the HSA, and would also allow the participant to make a federally tax-deductible contribution for healthcare expenses into their HSA.

[122] HHSC Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Waiver Proposal, July 13, 2011. http://www.hhsc.state.tx.us/Waiver-1115-proposal.pdf

[123] HHSC Presentation to the House County Affairs Committee on the Healthcare Transformation Waiver, May 15, 2014. http://www.tha.org/HealthCareProviders/Issues/FinanceandReimburse098F/MedicaidBBBFWaiver/House-County-Affairs-Committee-051514.pdf

Currently, state employees may participate in the TexFlex program by enrolling in a TexFlex account, a Flexible Spending Account (FSA) that allows employees to set aside money from their paychecks, pre-tax, to use for eligible out-of-pocket expenses.[124] Starting in 2015, TexFlex will allow members to roll up to $500 of unused funds over to the subsequent year; however, all funds in excess of $500 remaining in the account at the end of the year will be forfeited.[125] HSAs present several advantages over FSAs, not the least of which is the fact that HSA funds may be carried forward from year to year.[126]

HSAs are a tax-advantaged way of paying for medical expenses. HSAs are increasingly popular; an August 2010 *New York Times* article quoted an industry trade group to the effect that the number of people enrolled in HSAs stood at more than 10 million, up from 6.1 million in 2008.[127]

HSAs require a person to be covered by a HDHP, which under federal law must have at least a $1,200 deductible ($2,400 if the plan is family coverage). In addition, the annual out-of-pocket expenses for in-network services may not exceed $5,950 ($11,900 if the plan is family coverage).[128] These amounts are adjusted annually to account for inflation. The disadvantage of the high deductible is balanced by the tax advantages of an HSA and the lower premiums the HDHP charges.

Once a person is covered by an HDHP, he or she may contribute to an HSA. The amount contributed is not taxed. The saved money can be invested in a variety of ways and grows tax-free. The owner can make tax-free withdrawals on it to pay medical expenses, but there is a penalty under federal law if the money is used for non-medical expenses.[129] Not only are the contributions to HSAs tax-free, so are the earnings (e.g., the interest on the balance in the HSA). The cap on contributions to HSAs for 2011 is $3,050 (for a self-coverage plan) or $6,150 (for a family coverage plan).

A consumer can put money in the account up to the maximum federally mandated limit, and that money stays there until it is used for a qualified medical expenditure. (The money may be withdrawn for any purpose, but withdrawals that are not for qualified medical expenses are assessed a 10 percent tax penalty.)

[124] ERS TexFlex Health Care. http://www.ers.state.tx.us/Employees/Health/TexFlex_Health_Care/
[125] ERS FAQ TexFlex. http://www.ers.state.tx.us//Customer_Support/FAQ/TexFlex/?index=5
[126] "Health savings vs. flexible spending accounts," Hadley Malcolm, *USA Today*, Oct 7, 2013. http://www.usatoday.com/story/money/personalfinance/2013/10/07/comparing-health-savings-plans-flexible-spending-accounts/2843953/
[127] "High Deductible Plans Grow, But Not Everyone Should Get on Board,"Walecia Konrad, *New York Times,* August 27, 2010, available at http://www.nytimes.com/2010/08/28/health/28patient.html
[128] IRS Revenue Procedure 2010-22, available at http://www.irs.gov/pub/irs-drop/rp-10-22.pdf.
[129] The Patient Protection and Affordable Care Act (so-called "Obamacare") increases the penalty for withdrawing HSA funds for non-medical expenses, as well as removing over-the-counter medications purchased without a prescription from the list of "qualified medical expenses." Certain provisions of the PPACA may affect HSAs in the future, but specifics are not available because too much is contingent on regulations yet to be issued.

By allowing some employees to opt for HSAs the state can expect to generate cost savings compared to the traditional public employee health benefit plan provided by a Health Maintenance Organization (HMO). Research from the Michigan-based Mackinac Center for Public Policy found that in Michigan, the cost of public employee healthcare plans was increasing by 7.6 percent per year for HMO health insurance premiums. By contrast, the Mackinac Center noted that state costs for an HSA employee benefit package would grow, conservatively, at an annual rate of just 3.5 percent.[130]

The Mackinac Center also points out that contributing the maximum amount to employees' HSAs would be a significant benefit for state employees:

> This would be a huge benefit to state employees as very few employers provide health savings account users 100 percent premium support — much less full funding for HSAs. In fact, according to a survey of 6,000 employers by Information Strategies Inc., fewer than 10 percent of respondents contribute 100 percent of the allowed contributions.[131]

At the state level, Indiana has had significant success implementing HSAs for state employees. Seventy percent of Indiana's state employees are enrolled in HDHPs coupled with HSAs, which are offered as part of the standard benefits package for state workers. As a result of this high take-up rate, these employees have a total of $30 million in their accounts ($2,000 per employee) and their healthcare costs have fallen. Former-Governor Mitch Daniels (R-Indiana) reports:

> Most important, we are seeing significant changes in behavior, and consequently lower total costs. In 2009, for example, state workers with the HSA visited emergency rooms and physicians 67% less frequently than co-workers with traditional healthcare. They were much more likely to use generic drugs than those enrolled in the conventional plan, resulting in an average lower cost per prescription of $18. They were admitted to hospitals less than half as frequently as their colleagues... Overall, participants in our new plan ran up only $65 in cost for every $100 incurred by their associates under the old coverage.[132]

The private sector also demonstrated the significant fiscal benefits of HSAs. In April 2008, America's Health Insurance Plans reported that 6.1 million people are now covered by HSAs, a significant increase over the 4.5 million who were covered by HSAs a year earlier and almost double the 3.2 million account holders in 2006.[133] According to a survey of 152 large employers conducted by Deloitte Consulting, 40 percent of companies now believe that Consumer-Directed Health Plans combined with an HSA are "the most effective approach for managing costs and maintaining quality care."[134]

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[130] "State Should Adopt Health Savings Accounts," The Mackinac Center for Public Policy, September 28, 2007.
[131] *Ibid*.
[132] "Hoosiers and Health Savings Accounts," Editorial in the *Wall Street Journal,* March 10, 2010.
[133] America's Health Insurance Plans, Center for Policy and Research, April 2008.
[134] "Reducing Corporate Health Care Costs 2006 Survey," Deloitte Consulting LLP, 2006.

This proposal should have no fiscal impact on the state or the GBP because the HDHP offered to state employees would have lower premiums than the traditional benefits package. The difference between the costs of the two plans would be deposited in the employee's HSA. These deposits would be adjusted to ensure cost neutrality. As the Legislative Budget Board noted of a similar legislative proposal in 2013:

> The bill directs the state to contribute the excess over the cost of the high deductible plan, if any, of the amount that would otherwise be made on the member's behalf under HealthSelect to a health savings account. ERS reports that these amounts would be adjusted to neutralize the cost.[135]

Maintaining cost neutrality is therefore a critical component of this proposal.

Telemedicine

In the face of a surging population, concerns are growing over a physician shortage in Texas, particularly in the area of primary care.[136] In 2010, Texas had 165 physicians per 100,000 people, compared to the national average of 220 physicians.[137] The Department of State Health Services reports that 126 of the state's 254 counties do not have enough primary care physicians.[138] Meanwhile, the rising cost of healthcare is exacerbating problems created by the state's physician shortage.[139] As policymakers search for opportunities to improve access to care and contain costs, telemedicine has emerged as a promising means of delivering medical treatment of common, uncomplicated, non-emergent medical issues.

Telemedicine uses technology to deliver medical care to patients remotely. Texas regulations define telemedicine medical service as "[t]he practice of medical care delivery, initiated by a distant site provider, who is physically located at a site other than the site where the patient is located, for the purposes of evaluation, diagnosis, consultation, or treatment which requires the use of advanced telecommunications technology that allows the distant site provider to see and hear the patient in real time."[140]

[135] Legislative Budget Board Fiscal Note for HB 739 (83-R)
[136] "Despite Additional Dollars, Texas Doc Shortage Is Hard To Fix," Becca Aaronson, *The Texas Tribune* and *Kaiser Health News*, Aug 23, 2013. http://www.kaiserhealthnews.org/stories/2013/august/23/texas-doctor-shortage-medical-schools.aspx
[137] *Id.*
[138] *Id.*
[139] "Health Care Costs in Texas," The Texas Economy, Texas Comptroller of Public Accounts. http://thetexaseconomy.org/healthcare/costs/articles/article.php?name=healthcare
[140] 22 TAC 174.2(10)

Telemedicine offers significant access to care benefits to employees, rural residents, travelers, and the culturally isolated.[141] With telemedicine, employees are not required to take time off work in order to consult with a physician and can receive timely treatment and care.[142] Similarly, rural residents and travelers find telemedicine services a cost-efficient and convenient means of addressing certain health needs. Finally, the best telemedicine providers are able to offer a multilingual helpline 24 hours a day to help the most culturally isolated members of the workforce receive care in a manner comfortable to them.[143]

In light of growing interest in telemedicine, a new Federation of State Medical Boards model policy aims to create guidelines for its safe and appropriate practice. The policy parallels existing Texas Medical Board (TMB) rules, which say whether physicians and patients meet virtually or face-to-face, the standard of care remains the same.[144]

Currently, Texas law authorizes the use of telemedicine services. Supporting the expanded use of technology for telemedicine will increase access to affordable healthcare, particularly for Texans in rural areas. For these individuals, checkups and treatment for important health issues are often delayed due to a lack of access. Telemedicine encourages preventive care through expanded access.

To protect patients who seek treatment through telemedicine services, TMB Rules require that physicians who use telemedicine in their practices be licensed in all jurisdictions where their patients reside, adopt protocols to prevent fraud and abuse, discuss the risks and benefits of the service with the patient, and adhere to the same standards of appropriate practice that apply in traditional in-person clinical settings.[145] Importantly, TMB Rules also differentiate between two types of telemedicine: medical services delivered while the patient is present at an established medical site, and medical services provided at sites other than an established medical site. Patients may typically only receive treatment for previously diagnosed conditions under the second model after establishing a patient-physician relationship through a face-to-face visit or being referred by another physician who evaluated the patient in a face-to-face visit.[146] This means when a patient complains about an earache through a telemedical visit, if a physician would observe the ear canal or eardrum in a face-to-face visit, then that must occur during a telemedical visit as well.

[141] Tommy G. Thompson, et al, "A Model for Telephonic and Audio-Video Primary Care Medical Consults: Guidelines for Decision -Makers," 2013.
[142] *Id.*
[143] *Id.*
[144] Texas Medical Board Rules §174.8(b)
[145] Texas Medical Board Rules, Chapter 174
[146] Texas Medical Board Rules §174.7

Recommendation: Encourage pay parity for phone consultations by allowing a physician to charge for a telephone consultation with a covered patient if an employee benefit plan or health insurance policy allows any other person to charge for telephone consultations with covered patients.

The ability of doctors to communicate with their established patients by telephone offers a cost-effective means of improving healthcare outcomes in the state. Phone consultations provide patients with an alternative to costly urgent care and emergency room visits, and give physicians the flexibility to serve more established patients after hours virtually anywhere in the state.

Some insurers contract under exclusive relationships with vendors that provide telephone access to physicians located outside the state, while disallowing payment for the same activity among community physicians.[147] These vendor-contracted physicians may live outside the state and lack a relationship with the patient to whom they are providing services, as well as hospital admitting privileges in a regional hospital. Such physicians typically will not have means to physically treat and see patients in the follow up after the phone consultation.

By prohibiting insurance companies that pay physicians, including those physicians residing outside the state or the community, for telephone consultation services within the terms of an offered health plan from discriminating against local physicians offering similar services, lawmakers can promote continuity of care and decrease the number of expensive emergency room visits. Legislation introduced during the 83rd Legislative Session would have required payment parity for telephone consultations. While that legislation did not pass, the 84th Legislature should examine the issue of how best to address the issue of payment parity for telephone consultations.

Supporting the Medical Profession

Recommendation: Increase the number of residency positions available in Texas for medical school graduates.

Texas is a net importer of physicians; however, due to continued growth of the state's population, the ratio of physicians to 100,000 population has remained nearly stagnant.[148] In 2012, the national average of physicians per 100,000 population was 46.1 primary care physicians and 65.5 specialists.[149] Texas ranks near the bottom (43rd among the 50 states) for physicians per 100,000 population.[150]

[147] "Digital Doctor," Amy Lynn Sorrell, *Texas Medicine:* July 2014, pp. 20-24.
[148] "Graduate Medical Education Report," Texas Higher Education Coordinating Board (THECB), April 2012. http://www.thecb.state.tx.us/reports/PDF/2552.PDF?CFID=27934980&CFTOKEN=35363621
[149] "State Variability in Supply of Office-based Primary Care Providers: United States, 2012," Centers for Disease Control and Prevention (CDC), http://www.cdc.gov/nchs/data/databriefs/db151.htm
[150] "Feeding the Physician Pipeline: TMA forum promotes GME expansion," Medical Education, November 2013.

In 2012, Texas ranked 49th in the nation on the number of primary care physicians, with 33.6 per 100,000 population.[151]

Texas increased its medical school enrollments 31 percent from fall 2002 to fall 2012, growing from 1,342 to 1,760.[152] In 2011, Texas had 550 residency programs offering 6,788 residency positions.[153] Unless the state increases the number of first-year residency slots the Texas Higher Education Coordinating Board (THECB) estimates that approximately 137 graduates of the 2015 Texas medical school class will not find an entry-level residency slot in Texas.[154] To meet future physician demands, Texas must promote opportunities for the graduates of Texas' medical schools to obtain their residency training within the state.

During the 83rd Legislative Session, the Texas Legislature acted to address this problem with a $30 million increase in state funding for graduate medical education in the 2014-15 biennium.[155] The Legislature also appropriated $1,875,000 for Planning Grants and $7.375 million for Unfilled Position Grants and New and Expanded Program Grants.

The one-time planning grants were made available to entities that do not currently operate, and have not previously operated a GME program and are therefore eligible for Medicare GME funding. These $150,000 grants are intended to provide support for establishing GME programs in order to increase the number of first-year residency positions in the state.[156] Nine such grants were announced in December 2013, and THECB plans to the award three additional grants in fall 2014.[157]

[151] CDC, *Supra* at note 152

[152] "An Update on Graduate Medical Education in Texas," Texas Higher Education Coordinating Board (THECB), February 2013. http://www.thecb.state.tx.us/download.cfm?downloadfile=02B112C6-DCF0-6D3F-2EF7F570559D33F0&typename=dmFile&fieldname=filename

[153] THECB , *Supra* at note 155

[154] THECB , *Supra* at note 155

[155] See Senate Bill 1 and House Bills 1025 and 2550.

[156] House Bill 1025 (83R).

[157] "Graduate Medical Expansion Programs - 83rd Legislature - Status," Texas Higher Education Coordinating Board (THECB), August 2014. http://www.thecb.state.tx.us/reports/pdf/3123.pdf?CFID=15666688&CFTOKEN=74762637

Unfilled Position Grants and New and Expanded Program Grants are jointly funded, with a maximum allowable award of $65,000 per resident per year.[158] The Unfilled Position Grants may be awarded to accredited GME programs for the purpose of filling unfilled first-year residency positions; the New and Expanded Program Grants may be provided to entities with Accredited GME Programs to provide support to expand existing or establish new GME programs with first-year residency positions.[159] The grants are intended to pay for direct resident costs, including resident stipends and benefits.[160] 50 Unfilled Position Grants, totaling $3.25 million were awarded in FY 2014.[161] Approximately $4.2 million is available for Unfilled Position Grants and New and Expanded Program Grants in FY 2015, enough to cover approximately 64 positions.[162]

Texas lawmakers should continue to authorize funding in sufficient levels to support the Unfilled Position Grants and New and Expanded Program Grants for the 2016-17 biennium. Doing so will allow the state to continue to promote a much-needed expansion of first-year residency positions.

[158] *Id.*
[159] House Bill 1025 (83R)
[160] House Bill 1025 (83R)
[161] THECB, *Supra* at note 160
[162] THECB, *Supra* at note 160