HOUSE COMMITTEE ON APPROPRIATIONS

SUBCOMMITTEE ON ARTICLE II

INTERIM CHARGE 5:

Examine state investments in the health and brain development of babies and toddlers, including Early Childhood Intervention and other early childhood programs for children in the first three years. Evaluate opportunities to boost child outcomes and achieve longer-term savings.

The following constitute responses to a request for information regarding the above interim charge posted on July 27, 2020.

LEGISLATIVE BUDGET BOARD

Early Childhood Intervention

Overview and Funding

PREPARED FOR HOUSE APPROPRIATIONS SUBCOMMITTEE ON ARTICLE II

LEGISLATIVE BUDGET BOARD STAFF **OCTOBER 2020**

Committee Charge

House Appropriations Committee Subcommittee on Article II Interim Charge 5 - Examine state investments in the health and brain development of babies and toddlers, including Early Childhood Intervention (ECI) and other early childhood programs for children in the first three years. Evaluate opportunities to boost child outcomes and achieve longer-term savings.

Presentation Overview

- ECI program background;
- ECI funding;
- ECI performance measures; and
- General Appropriations Act (GAA) ECI riders.

ECI Program Background

- Provides services to children up to age three.
- Eligible children must have at least one of the following:
  - Developmental delay;
  - Certain medically diagnosed conditions; or
  - Auditory or visual impairment.
- HHSC contracts with local organizations to provide services.

ECI Funding

Funding for ECI client services is provided within the GAA and outside of the GAA.

Funding within the GAA includes:

- Direct appropriations to the program; and
- Appropriations for Medicaid and the Children's Health Insurance Program (CHIP) used to provide certain therapies and other services.

Funding outside the GAA includes:

- Other insurance collections (private insurance and TRICARE);
- Family cost sharing; and
- Other locally collected funds.

Additional funding is provided within the GAA for ECI training, evaluation, technical assistance, respite services, and state office expenditures in Strategy D.1.4, ECI Respite and Quality Assurance.

- Funding has been fairly stable, totaling $6.9 million in the 2018-19 biennium and $7.1 million in the 2020-21 biennium
- Prior to the 2018-19 biennium, state office expenditures were in Strategy D.1.3, ECI Services

ECI Services Funding within the GAA Fiscal Years 2016 through 2021

IN MILLIONS	2016 Expended	2017 Expended	2018 Expended	2019 Estimated	2020 Appropriated	2021 Appropriated
General Revenue	$31.8	$28.3	$32.0	$29.8	$45.6	$45.6
Foundation School Funds	$16.5	$16.5	$16.5	$16.5	$16.5	$16.5
Federal Funds						
Medicaid Federal Funds	$26.5	$30.9	$32.1	$33.7	$35.6	$36.9
IDEA Part B	$5.1	$5.1	$5.1	$5.1	$5.1	$5.1
IDEA Part C	$31.9	$44.9	$37.7	$43.1	$51.9	$52.7
TANF	$10.0	$10.0	$14.3	$14.4	$15.0	$15.0
Subtotal, Federal Funds	*$73.5*	*$90.9*	*$89.2*	*$96.3*	*$107.6*	*$109.8*
Subtotal, ECI Services Strategy	**$121.9**	**$135.7**	**$137.7**	**$142.6**	**$169.7**	**$171.9**
Medicaid and CHIP Strategies	$41.7	$37.5	$42.1	$42.1	See note 3 below	
Grand Total, within the GAA	**$163.6**	**$173.2**	**$179.8**	**$184.7**		

Notes:
(1) Does not include funds appropriated for training, evaluation, technical assistance, respite services, or state office expenditures in Strategy D.1.4, ECI Respite and Quality Assurance.
(2) Includes state office expenditures in fiscal year 2016 to 2017. Funding was moved to Strategy D.1.4, ECI Respite and Quality Assurance, in the 2018-19 GAA.
(3) Funding in the Medicaid and CHIP Strategies is estimated and includes General Revenue Funds and Federal Funds. Amounts for 2020-21 have not been identified.
(4) Amounts may not sum due to rounding.
Source: Legislative Budget Board; Health and Human Services Commission.

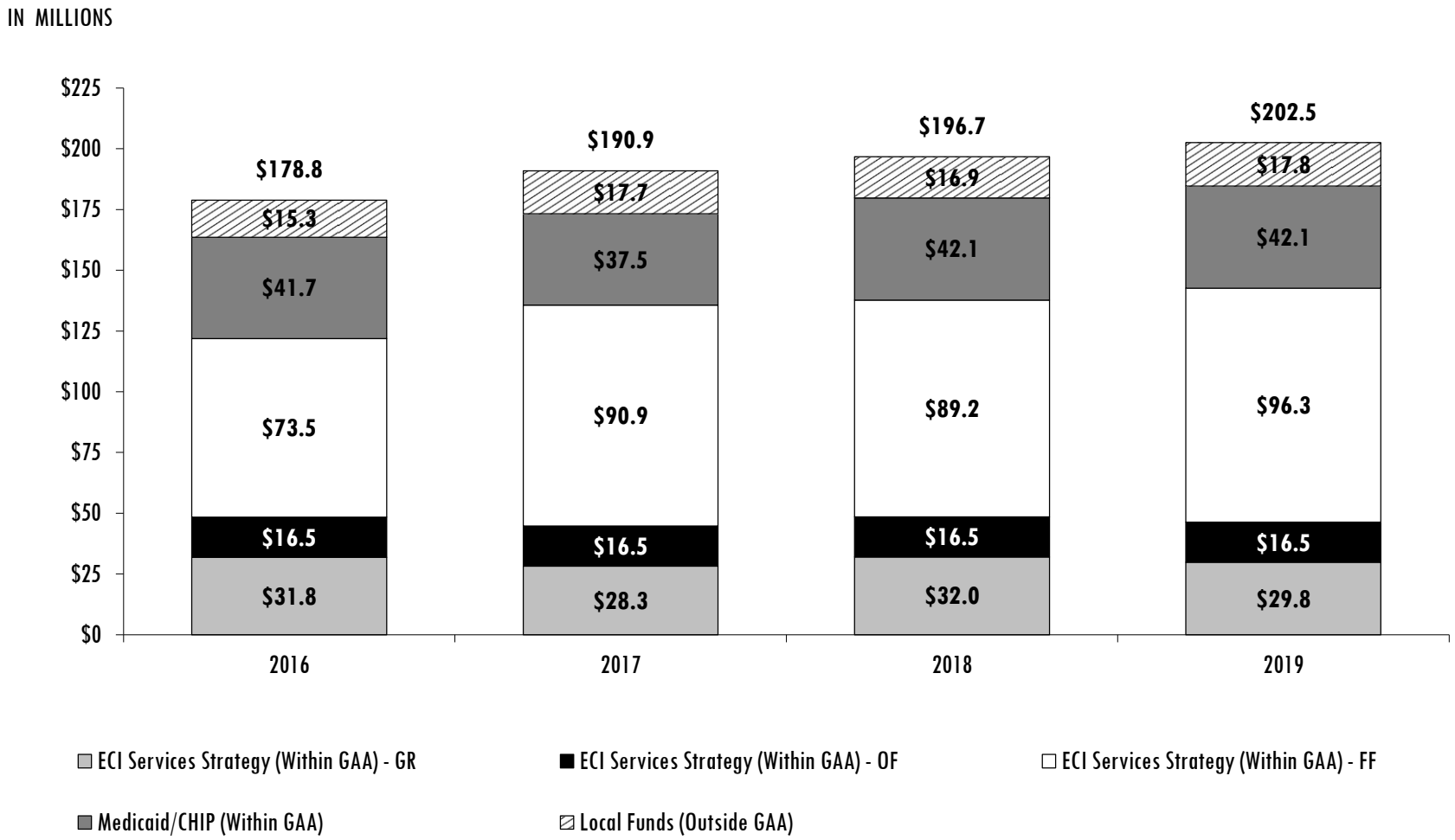
ECI Funding outside the GAA
Fiscal Years 2016 through 2019

IN MILLIONS	2016	2017	2018	2019
Private Insurance	$5.1	$5.7	$5.4	$6.3
TRICARE	$1.2	$1.4	$1.6	$1.7
Family Cost Share	$1.9	$2.2	$2.2	$2.5
Other Locally Collected Funds	$7.1	$8.5	$7.7	$7.4
Total ECI Funds Outside the GAA	**$15.3**	**$17.7**	**$16.9**	**$17.8**

Notes:
(1) Other Locally Collected Funds include local city/county grants, grants from non-profit organizations, foundation funding, donations, or other cash or in-kind contributions.
(2) Amounts may not sum due to rounding.

Source: Health and Human Services Commission

Total ECI Services Expenditures Fiscal Years 2016 through 2019



Appropriations Compared to Expenditures

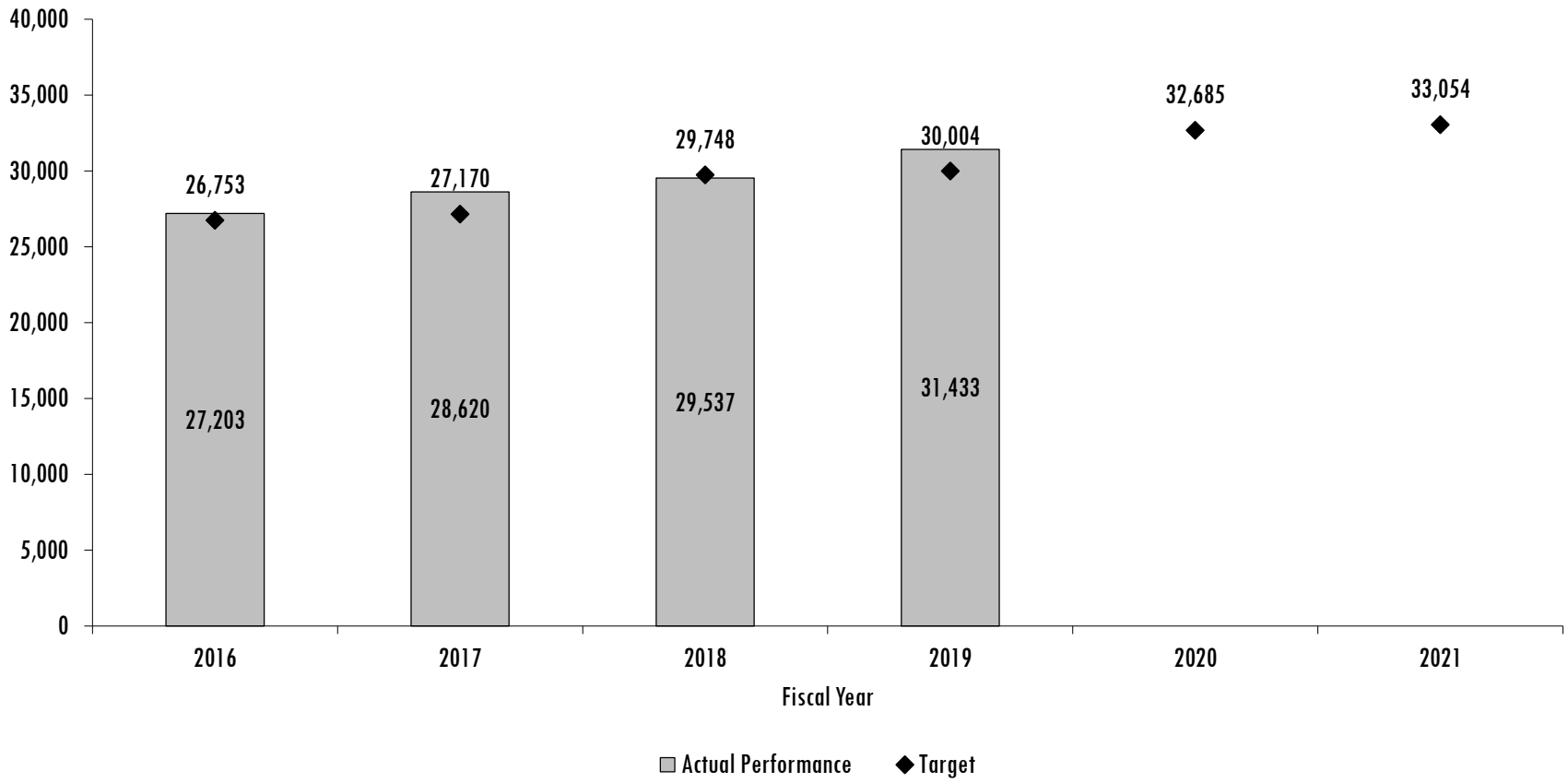
IN MILLIONS	2016	2017	2018	2019
Regular Appropriations	$140.3	$142.5	$147.0	$148.3
Supplemental Appropriations	-	$4.5	-	$1.5
Total Appropriations	**$140.3**	**$147.0**	**$147.0**	**$149.8**
Approved Requests to Exceed (RTEs)	-	$2.2	$0.1	-
Total Approved Funding	**$140.3**	**$149.2**	**$147.2**	**$149.8**
Actual Expenditures	$121.9	$135.7	$137.7	$142.6
Expenditures Over/(Under) Funding	**($18.4)**	**($14.2)**	**($9.5)**	**($7.3)**

Amounts identified as expenditures under funding include Medicaid Federal Funds that were not drawn due to a lack of eligible expenditures, TANF Federal Funds not spent due to a lack of eligible children, and IDEA Part C Federal Funds that were not expended.

Notes:
(1) Expenditures do not include Medicaid/CHIP funds expended for therapies.
(2) Amounts may not sum due to rounding.

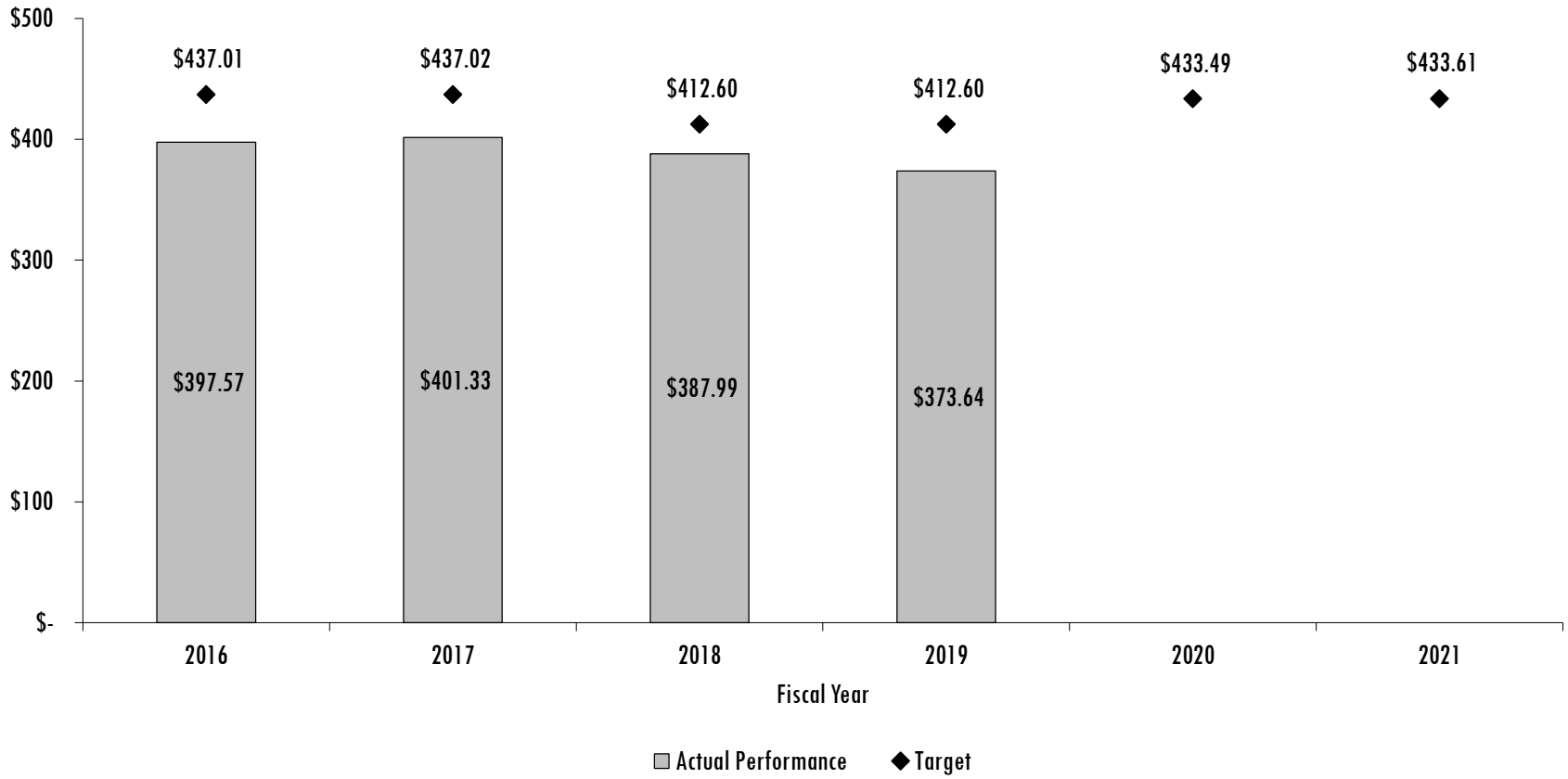
Source: Health and Human Services Commission.

Average Monthly Number of Children Served in Comprehensive Services



Note: Targets for fiscal years 2020 and 2021 are established by the Eighty-sixth Legislature, General Appropriations Act (GAA), 2020-21 Biennium.
Source: Health and Human Services Commission.

Average Cost Per Child Per Month



Note: Targets for fiscal years 2020 and 2021 are established by the Eighty-sixth Legislature, General Appropriations Act (GAA), 2020-21 Biennium.
Source: Health and Human Services Commission.

ECI GAA Riders

The 2020-21 GAA contains several riders regarding the ECI program, including:

- Rider 81, Maintenance of Effort (MOE) Reporting Requirements: ECI Services – requires a quarterly report on state funds used to meet MOE for federal IDEA Part C funds
- Rider 82, Education Funding – requires HHSC to enter into an Memorandum of Understanding with the Texas Education Agency and submit a copy to the LBB and Governor
- Rider 83, Limitation on Federal Funds Appropriations for Early Childhood Intervention Services – prohibits expenditure of IDEA Part C funds in excess of appropriations without prior written approval
- Rider 85, Reporting on Early Childhood Intervention – requires several reports and notification in the event a provider is going to terminate services
- Rider 98, Early Childhood Intervention Funding Maximization – requires a plan to maximize funding available to ECI providers and progress reports related to funding maximization

Rider 98, Early Childhood Intervention Funding Maximization

- Requires HHSC to develop and submit a plan for maximizing funding available to providers of ECI services. Strategies in the plan may include:
  - Evaluating the Medicaid rate for Specialized Skills Training;
  - Restructuring ECI provider contracts to ensure expenditure of ECI appropriations, which may include adjusting the maximum reimbursable value to allow expenditure of appropriated funds for quality or incentive payments to ECI providers;
  - Coordinating with the Texas Education Agency to explore the feasibility of drawing down additional Federal Funds to be transferred to HHSC for ECI services;
  - Working with the Centers for Medicare and Medicaid Services (CMS) and any other federal partners to identify additional opportunities to access federal funds to support the ECI program; and
  - Any additional strategies identified by HHSC.
- Requires HHSC to submit progress reports identifying strategies HHSC has implemented and the impact of the strategies, strategies HHSC plans to implement and a timeframe for implementation, and any challenges in maximizing funding available to providers of ECI services identified by the agency.
- Plan was due on September 1, 2019, and progress reports on March 1, 2020; September 1, 2020; and March 1, 2021.

ECI Funding Maximization

According to the initial plan and first two progress reports, HHSC has/is:

- Concluded that changing the structure of contracts is unlikely to result in contractors expending the maximum amount of funding available;
- Determined the use of quality incentive payments is not a good fit for the program's current contract and reimbursement structure;
- Exploring feasibility of strategies to maximize Medicaid and CHIP funding;
- Notified contractors that TCM events can be pooled across one day;
- Reviewing technical assistance materials;
- Exploring possibility of WIC dietitians providing Part C nutrition services to WIC-eligible children who are enrolled in ECI and need specialized nutrition services;
- Bulk purchasing electronic record forms for the Battelle Developmental Inventory;
- Using the HHSC warehouse to fulfill distribution of outreach publications; and
- Exploring possibility of outsourcing third-party billing for ECI services.

Contact the LBB

Legislative Budget Board
www.lbb.state.tx.us
512.463.1200

HOUSE FORMAL REQUEST FOR INFORMATION (RFI)

COMMITTEE: APPROPRIATIONS S/C ARTICLE II

INTERIM CHARGE 5: EARLY CHILDHOOD INTERVENTION

Interim Charge

Examine state investments in the health and brain development of babies and toddlers, including Early Childhood Intervention and other early childhood programs for children in the first three years. Evaluate opportunities to boost child outcomes and achieve longer-term savings.

Program Overview

Early Childhood Intervention (ECI) is a statewide program for families with children, birth to three years old, with disabilities and developmental delays – regardless of income or insurance status. The Texas Health and Human Services Commission (HHSC) operates the program through cost-reimbursement contracts with 41 local agencies that provide developmental services such as speech, occupational and physical therapy; audiology and vision services; and case management. Services are individualized based on the needs and concerns of each family and child, and providers use a coaching model to help parents learn to incorporate interventions into daily routines.

ECI and Brain Development

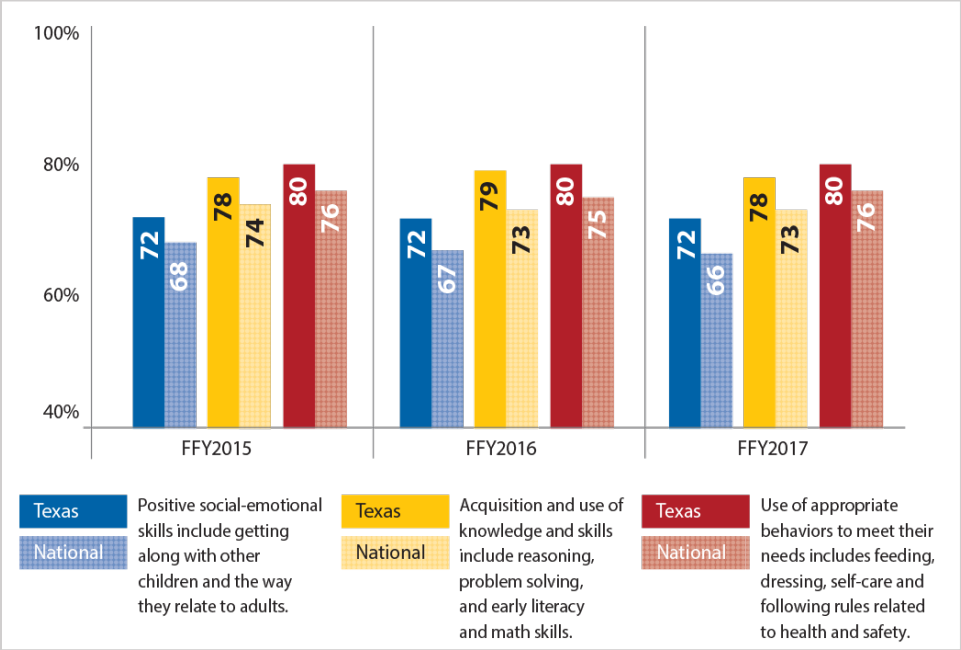
ECI services provide immediate and long-term benefits for children and families. These services enhance the child's development during the early stages of life when the brain is developing rapidly and enrich the capacity of families to meet their child's needs. Between birth to 36 months, a child learns how to communicate, begin to take care of themselves, explore their world, exercise some self-control, and form relationships.

Getting intervention early when needed is so important because we know from brain science that a child's brain will reach nearly 90 percent of the weight of an adult's brain by the time they are age three. In the first few years of life, 700 to 1,000 new neural connections form every second. Early childhood experiences have lifelong

effects, both positive and negative, which means early childhood is a period of both great opportunity and great vulnerability.[i]

ECI services help families understand how to encourage the natural growth and development that occurs in all children—and apply that knowledge to their own child. Children in Texas consistently experience significant growth as a result of ECI participation.

Texas ECI Child Outcomes



IDEA Part C Requirements

ECI is provided under the Individuals with Disabilities Education Act (IDEA) Part C, which requires the program to largely function as an entitlement program. However, IDEA Part C funding is capped and has remained relatively level for multiple years despite increased population and caseload growth. Federal regulations also require that services must be provided statewide; families should be served in their natural environments (homes and other community settings); and the program cannot implement a wait list.[ii]

Sustainability Challenges

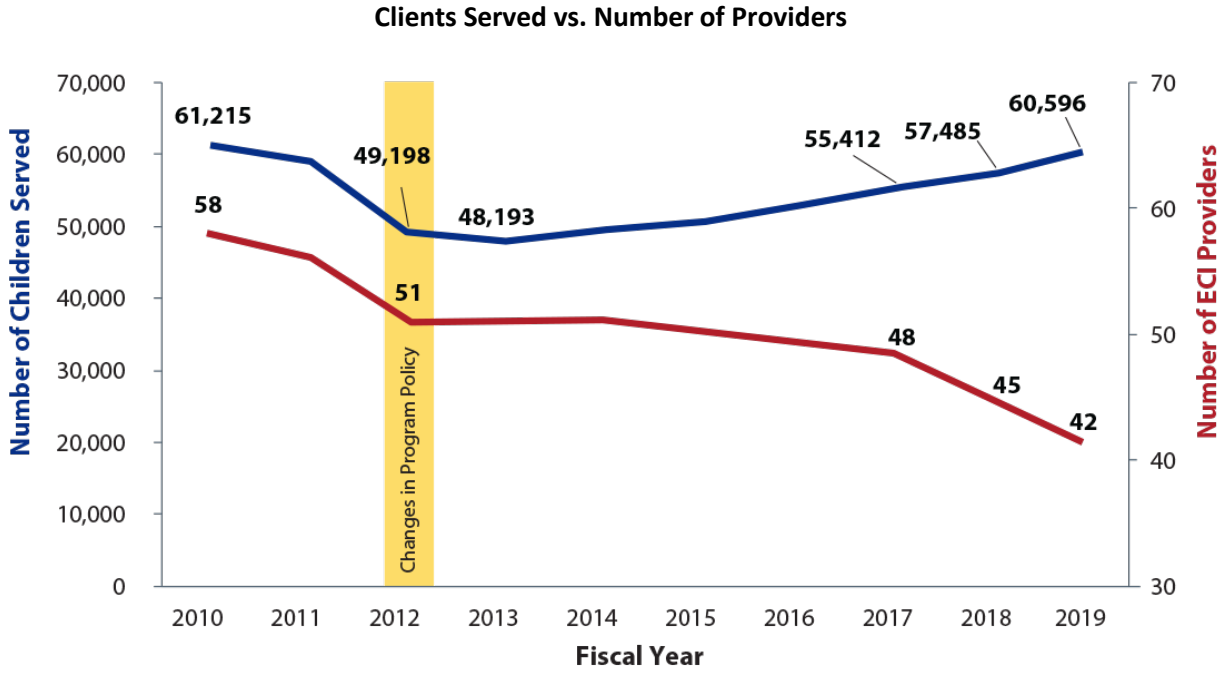
While HHSC funds contractors based on an average number of children enrolled each month, IDEA Part C regulations require providers to serve all children determined eligible. Therefore, if the number of children determined eligible exceeds the average

number of children included in the contract, the ECI contractor must still serve those children, regardless of funding.

In each of the last six fiscal years, more than 93 percent of ECI contractors served a greater number of children than the target number of children listed in their contract. If a contractor's expenses exceed what they can bill or be reimbursed from the state for, they are out that difference.

If contractors withdraw from the program and the remaining or new contractors are unable to absorb the children served in those areas, the ECI program no longer has statewide coverage and is in violation of IDEA Part C regulations. Any gaps in coverage can put the state at risk for litigation.

The number of ECI contractors has declined since 2010 from 58 to 42 as of 2019.[1] 7,622 children in 83 Texas counties have been impacted by these contractor transitions.



Infusion of Funds and Impact on Sustainability

The 86th Legislature made a significant investment in ECI, including $1.5 million in supplemental funding for Fiscal Year (FY) 19 and an increase of $31 million in General Revenue and $48 million in all funds for the 2020-21 biennium, for a total appropriation of $169.7 million in FY20 and $171.9 million in FY21. Below is a

[1] ECI has 41 contractors as of September 2020, following a competitive procurement.

summary of how the funds were utilized and how the ECI system is doing as a whole since those funds were distributed.

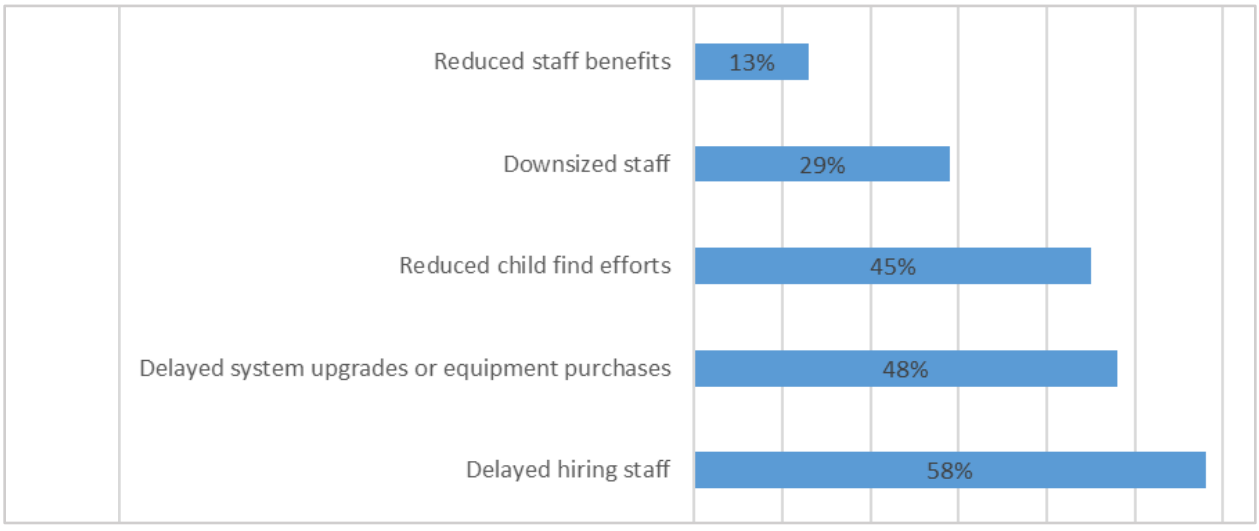
Fiscal Year 2019 Supplemental Funding:

The $1.5 million in supplemental funding for FY19 was distributed in August 2019 to 11 contractors that were serving significantly over their contractual target of enrolled children and meeting the performance target for delivered hours. This funding came at a critical time – the end of the fiscal year, when providers are working to reconcile funding with expenditures and prepare to sign another contract with HHSC to continue services. All ECI providers signed a contract to continue providing services in FY20.

To gauge impacts on sustainability, HHSC conducted a survey of providers in March 2020; responses were due before the COVID-19 impacts would have been experienced. A similar survey had been conducted in 2017, which allowed for comparison.

In 2017, 90 percent of respondents said they took significant cost-saving measures; however, in FY19, the percentage dropped to 77 percent. In each of the categories of cost savings measures HHSC asked about (e.g., delaying hiring of staff, reducing staff benefits, or reducing efforts to find eligible children), the percentage is either equal to or lower than the results in 2017.

77 percent of contractors that responded report engaging in one or more of the following cost-saving measures:



In FY19, 40 percent of all contractors had to contribute funds from other lines of their agency business to keep their ECI programs in the black. This is an increase from 30

percent of contractors in 2017. In FY19, the amount of funds contributed ranged from about $10,000 to $1.7 million. This is also an increase from the last survey, where the amount of funds contributed ranged from a few hundred dollars to almost $800,000. Overall, the FY19 supplemental funds made a positive impact on the cost-saving measures ECI providers made within their organizations; however, a significant portion had to leverage other agency funds to sustain their programs – and at a higher level of investment than in 2017.

Fiscal Year 2020 Exceptional Item Funding:

All contractors received an increase as a result of the FY20 Exceptional Item funding. HHSC utilized a standard, metrics-based methodology to allocate funding directly to providers to fund their caseload. The ECI funding allocation process considers past performance, projected population growth, and caseload mix to determine funding levels for each contractor.

HHSC also set-aside $1 million for mid-year adjustments. Six ECI contractors qualified for adjustments totaling $605,460 based on targets set for children served and hours of services delivered, and one contractor was awarded an additional $8,750 for training completed earlier in the year. The remaining $385,790 in contractual funds was distributed to contractors based on need arising from the COVID-19 pandemic, including costs to shift to a telehealth model.

HHSC conducted a survey of ECI contractors in mid-June to identify which contractors needed additional funds, and how much, and those who may lapse funds. Fifteen contractors reported a need for additional funds estimated to be between $2,963,155 and $3,325,449, and nine contractors reported they expected to lapse between $2,470,364 and $2,705,364 in contractual funds. HHSC executed amendments to redistribute a total of $2,660,790.

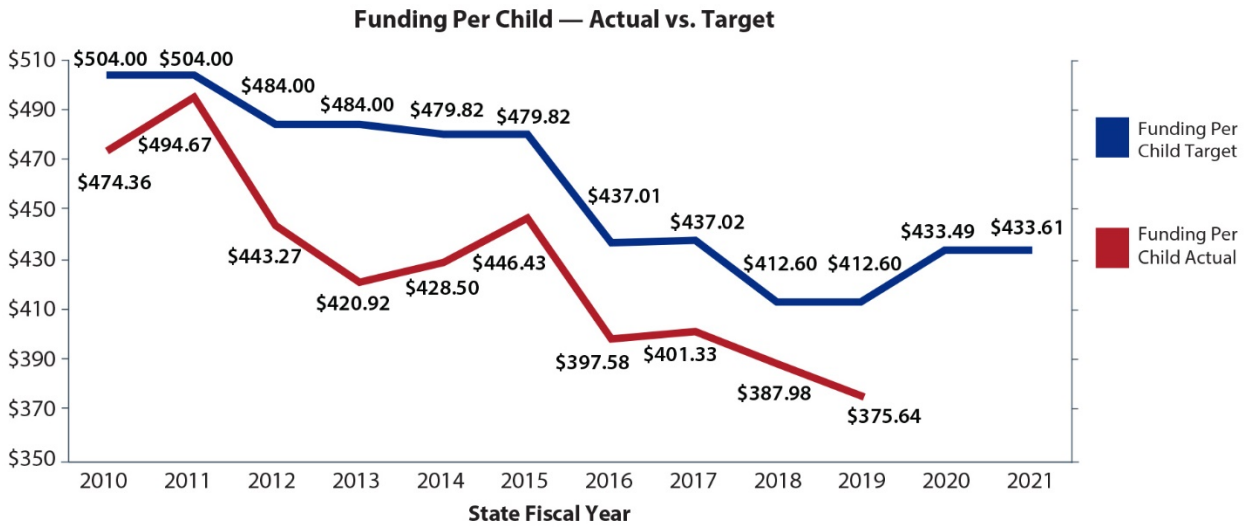
In the March 2020 survey, of the 42 contracted providers at the time, 31 provided a glimpse into their financial sustainability status in FY20 prior to the COVID-19 pandemic. Thirty-five percent (11 respondents) said the FY20 increase would meet all outstanding funding needs. Sixty-five percent (20 respondents) reported that the FY20 increase would fill some, but not all, of the anticipated financial deficits. HHSC also asked about organizations' discussions around financial constraints that are expected to lead to conversations about discontinuing ECI services. Eighty-four percent (26 respondents) did not anticipate that their organization will have discussions this year about exiting the program. However, five contractors indicated they did anticipate that their organizations would have these conversations.

Fiscal Year 2021 Exceptional Item Funding:

To disseminate the FY21 funding, HHSC initiated a competitive procurement. All 254 counties were included in at least one respondent's request. Forty-three applications were submitted by 42 organizations and 41 contracts were awarded. Collectively, respondents requested $4.1 million above the available contract dollars in FY21.

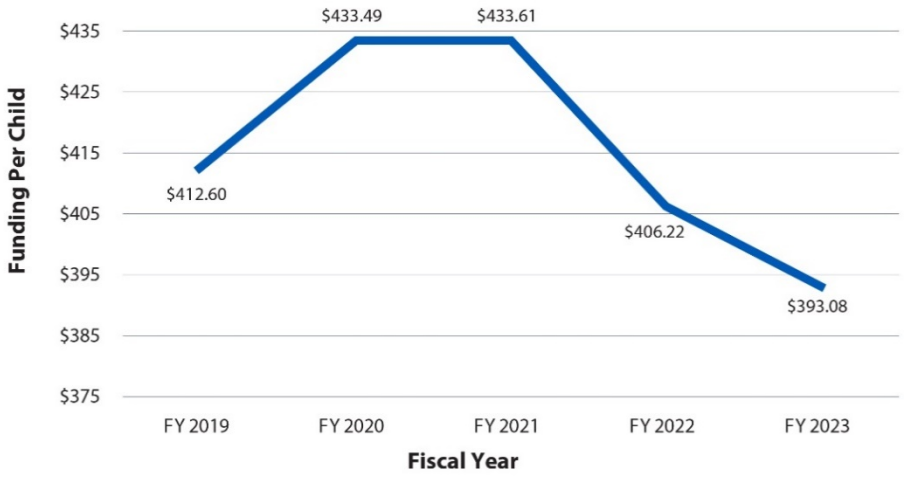
The Next Biennium:

In looking at the funding per child in the General Appropriations Act, the 86th Legislature made a positive impact on the downward trend of per-child funding. The FY20-21 funding per child of $433 reverses a more than eight-year decline in the target funding levels per child.



Projecting caseload out to FY22-23, if the total ECI appropriation is unchanged, providers will experience a cut, as the funding per child will decrease from $433 per child to $406 per child in FY22 and $393 per child in FY23.[2]

[2] Based on March 2020 HHS Forecasting caseload projections.



COVID-19 Impacts and HHSC Response

ECI providers had to shift almost overnight to a telehealth model when COVID-19 hit. Prior to the pandemic, fewer than five ECI contractors were routinely leveraging telehealth. As of the week of April 20, 2020, all 42 contracted ECI programs were providing services via telehealth due to COVID-19. This immediate shift provided some challenges for providers to acquire the necessary equipment for both staff and families, ensure communication with families was timely and clear, and to adapt service provision as allowable and appropriate to ensure continuity of services. Four programs briefly closed in order to make adjustments and provide training to staff prior to moving to telehealth services. At this time, about half of ECI contractors have resumed some services in the home or begun conducting some evaluations in the office, but many remain in a 100 percent telehealth model.

Over half of ECI providers' budgets are collected locally, meaning providers access most of their funding through billing public and private insurance for reimbursable services. Referrals to ECI and hours of services delivered to families have been depressed by the pandemic and, therefore, so has contractors' ability to bill, resulting in loss of revenue and additional financial strain on the system. In April 2020, referrals were down 43 percent and average delivered service hours were down 30 percent when compared to April 2019. As of July 2020, referrals were down 16 percent and delivered hours were down 19 percent from where they were in July 2019.

In response to COVID-19, HHSC expanded Medicaid reimbursement for ECI telehealth services to include all Medicaid reimbursable services so that, in addition to ECI services like occupational and speech therapy and specialized skills training, which became eligible for Medicaid reimbursement when delivered via telehealth earlier this year, other ECI services like physical therapy, nutrition, and targeted case

management delivered via telehealth and specialized skills training and nutrition delivered over the phone are also temporarily being reimbursed by Medicaid to facilitate the provision of remote services to families.

HHSC has been in constant communication with providers to help support continuity of services. HHSC has released a questions-and-answers document that is updated routinely to assist with ongoing provider questions, including nuances of policy implementation, documentation, and billing during the pandemic. HHSC has hosted weekly or bi-weekly calls with contractors, provided extensive follow-up individually with providers and sent out guidance with each policy interpretation or programmatic flexibility that is identified. An example is helping providers adapt the eligibility determination tool to a telehealth environment.

Some programs that moved to telehealth immediately did not have electronic signature technology that meets federal privacy requirements, which is necessary to document parental consent for services remotely. The ECI office leveraged administrative dollars to purchase this technology and made it available to help fill this gap. The ECI office also purchased electronic versions of some required forms that providers could not access when they were unable to return to their physical offices to obtain copies.

Eleven ECI contractor agencies applied for and received Paycheck Protection Program (PPP) loans. Because these loans are available only for private entities, some ECI contractors such as school districts and education service centers are not eligible for PPP loans. HHSC has provided ECI contractors with information on the CARES Act Provider Relief Fund. At this time, HHSC does not have information on how many ECI contractors have applied for this funding.

Due to unanticipated supplemental funding, delays in hiring, or other impacts of COVID-19, some ECI contractors indicated they would not expend all their ECI contract funds by the end of the fiscal year. Others indicated they anticipated a shortfall due to unanticipated costs, decreased caseloads, or other impacts on their ability to bill for services during COVID-19. Therefore, HHSC facilitated the return of anticipated surplus funds and disbursement of those funds to other ECI contractors in need in the final months of FY 2020.

Overall, the pandemic has amplified some ECI contractors' concerns with financial stability; however, at this time, HHSC has coverage for all Texas counties for FY21.

Opportunities to Boost Child Outcomes and Achieve Longer-Term Savings

As described earlier, Texas child outcomes in ECI consistently exceed the national average. Many children who receive ECI services ultimately do not need special education services or need less intensive services once they start attending school. The National Early Intervention Longitudinal Study tracked children at risk of needing special education and found 46 percent did not need special education by the time they reached kindergarten as a result of early intervention services.[iii] One Texas school district, Katy ISD, estimated that ECI services have saved the district over $1 million annually in special education costs.

ECI is currently working with the Rice University Texas Policy Lab on a research project to systematically measure cost savings and other downstream benefits of ECI to other state programs. Preliminary findings from that research are anticipated in 2021.

Sources of Information

ECI Rider 98 Report, September 1, 2020.
https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/eci-implementation-plan-progress-reports-sept-2020.pdf

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[i] The Center on the Developing Child – Harvard University:
https://developingchild.harvard.edu/science/key-concepts/brain-architecture/

[ii] Code of Federal Regulations, Title 34, Part 303,
Early Intervention Program for Infants and Toddlers with Disabilities

[iii] National Early Intervention Longitudinal Study (NEILS):
https://www.sri.com/sites/default/files/publications/neils_finalreport_200702.pdf

Input to Appropriations/Subcommittee on Article 2 - 2020

Interim Charge #5: Examine state investments in the health and brain development of babies and toddlers, including Early Childhood Intervention and other early childhood programs for children in the first three years. Evaluate opportunities to boost child outcomes and achieve longer-term savings.

Family Connects is an evidence-based model that combines engagement and alignment of community services and resources with short-term nurse home visiting beginning in the first month after birth. Family Connects is designed to be provided to all families with newborns, voluntarily and at no cost to the family.

The program aims to create systems change at the population level to advance the well-being of all children and their families by:

- Ensuring that families have a medical home
- Providing physical- and mental-health screenings
- Assessing family strengths and needs comprehensively
- Connecting families to community resources that support their individual family needs and preferences

Family Connects programs are in various stages of planning and implementation in 42 sites across 16 states. Programs are currently operating in 5 counties in Texas:

- Bastrop (administered by Bastrop County & Bastrop County Cares and Lone Star Circle of Care)
- Bexar (administered by the United Way of San Antonio and Bexar County and the Catholic Charities Archdiocese of San Antonio, Inc.)
- Tarrant (administered by My Health My Resources (MHMR) of Tarrant County)
- Travis (administered by the United Way for Greater Austin and Austin Public Health)
- Victoria (administered by the Victoria County Public Health Department and the South Texas Assessment and Referral Services (STARS) Clinic)

The Texas programs are funded through a mix of mix of federal and state funds administered through the Prevention and Early Intervention Division at DFPS (C.1.4 & C.1.5) as well as local philanthropic and managed care organization investments.

Across the country, Family Connects programs are funded through a variety of means including Title V, Medicaid reimbursement, Federal MIECHV (approved as a screening tool when combined with another approved model), Preschool Development Grant, education funding, other state or local funds and an innovative statewide rollout of Family Connects in Oregon via Senate Bill 526 that requires health benefit plans to reimburse the cost of universally offered newborn nurse home visits.

Family Connects International (FCI), based at the Center for Child & Family Policy at Duke University, disseminates the Family Connects model. Training and technical support is managed by the non-profit Center for Child & Family Health. FCI works with local and state governments, health-care systems, and nonprofits to plan and implement the model. FCI also conducts rigorous research and evaluation of the model, as well as innovative research on early childhood well-being and parent-child relationships.

The Family Connects model is a population-health intervention that aims to reach every family with a newborn in a given community (including adopting, fostering and kinship-care families, as well as mothers who have experienced a loss or are separated from their newborn). This universal approach screens all families in a population at a specific time point, identifying family-specific risks and connecting each family with community resources that can help them mitigate those risks.

Reaching all families in a community has a positive impact on health at a population level. Population health is the health outcomes of all individuals, most often defined by shared geography (communities, cities, states, nations). Health-care professionals partner with these populations to promote health, prevent disease, and address health inequities. Achieving population impact in a community necessitates reaching a significant number of people within that community. That’s why the Family Connects model requires that our disseminating partners reach at least 60% of the eligible population.

All families have needs around the birth of a child. While all families have needs, those needs vary across families based on the stresses they may be experiencing: financial concerns, interpersonal violence, isolation, lack of knowledge regarding infant care and child development, maternal

depression, or simply the challenge of coping with a crying infant. The Family Connects randomized controlled trials (RCT) revealed that 94% of families seen had one or more needs for specific education, recommendations, or community service referrals.

The Family Connects model does not replace more intensive home visiting programs for those families that need and choose them. Rather, it serves as a screening and triage approach to ensure optimal matching of families with other community services.

Offering a universal newborn nurse home visiting program to everyone can remove any stigma associated with accepting this type of service and can normalize a postpartum assessment/triage service as a regular part of delivering babies within the community.

Published results from two randomized controlled trials show the model has positive effects in a number of key areas including those that impact or reflect child health or development outcomes:

-Mothers were 28% less likely to report possible clinical anxiety at infant age 6 months.

-Mothers reported more positive parenting behaviors and were more responsive to their baby at age 6 months.

-Mothers were more likely to complete their 6-week postpartum health check.

-Total child emergency room visits and hospital overnights were reduced by 50% through age 12 months and 37% through age 2 years

-$3.17 reduction in total hospital billing costs for every $1.00 in program costs.

-Total child maltreatment investigations reduced by 44% through child age 2

-Home environments were safer and homes had more materials to support infant learning and development at age 6 months.

-Families reported more connections to community resources and more frequent use of services at infant 6 months.

Sources:

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RESPONSE TO FORMAL REQUEST FOR INFORMATION
HOUSE APPROPRIATIONS SUBCOMMITTEE ON ARTICLE II

CHAIR: REP. SARAH DAVIS

RESPONSE SUBMITTED BY:
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> Interim Charge #5: Examine state investments in the health and brain development of babies and toddlers, including Early Childhood Intervention and other early childhood programs for children in the first three years. Evaluate opportunities to boost child outcomes and achieve longer-term savings.

An overview of the Children's Learning Institute and the Texas School Ready Program

The Children's Learning Institute (CLI) at The University of Texas Health Science Center at Houston is dedicated to ensuring that all children reach optimal potential, and the cornerstone of CLI is applying cutting-edge research in child development and education to improve learning. One of CLI's most successful programs is Texas School Ready (TSR) – a program aimed at helping at-risk preschool-age children be better prepared for kindergarten and beyond. TSR is the result of more than sixteen years of research, implementation, and innovation. The core of TSR is a three-year professional development program that provides high-intensity support to early education teachers in communities that are most in need of quality resources and individualized technical assistance. This support includes research-based curriculum, classroom materials, technology-driven child progress monitoring, teacher/staff professional development with one-on-one coaching, and ongoing program evaluation. TSR coaches teachers both onsite and remotely, with remote teachers receiving coaching through video and technology-driven feedback.

Child care programs are eligible to participate if they serve at least 50% at-risk children meeting eligibility requirements for state-funded prekindergarten and/or at least 50% children eligible to receive Child Care Management System (CCMS) funding. All Head Start programs are eligible, as are public school preK programs if they are partnered with a child care or Head Start program.

Every two years, community-based organizations can apply to become TSR "lead agents," serving as the hub for TSR in their local community. These lead agents recruit eligible programs to participate in the program. In 2014, TSR launched a web-based platform to house its high quality program improvement tools, known as CLI Engage. CLI Engage now serves as the backbone of TSR, delivering the program's professional development courses, child progress monitoring tools, supplemental lessons, and more.

CLI also developed the nationally renowned parent program, *Play and Learning Strategies* (PALS). PALS is a research-based program that helps parents understand early childhood brain development and support the social-emotional, cognitive, and language development of infants, toddlers, and preschoolers. With the help of a trained coach, parents learn specific behaviors that help them tune in to their children's needs, practice "serve and return" in a sensitive and contingent manner, and provide appropriate cognitive and language stimulation. PALS coaching has been adapted in multiple projects to be delivered one-on-one with family members, in facilitated group-based sessions, and remotely (i.e., using web conferencing software).

How have CLI programs improved child outcomes and achieved long-term savings?

Using the assessment tools on CLI Engage, TSR routinely measures performance of professional development efforts in terms of both gains in specific teaching practices and gains in student skills important for school readiness.

For example, TSR classrooms are located in one of three settings: private childcare, Head Start, or public prekindergarten. While each of these partnership classrooms serves at-risk children, we have found that the children served by these settings have differing skill levels at the beginning of the year, with public school enrolling students with the least developed skills. Each year we analyze the differences in skill growth across early learning domains (e.g., book and print knowledge, early writing skills, letter knowledge, mathematics, phonological awareness, vocabulary, and social-emotional skills), and find that, by the end of the preschool years, differences in skill levels across settings narrow for most domains. This demonstrates that children in TSR are leaving preschool with similar levels of skill, regardless of early education setting.

We also analyze the growth of children who enter the program with the least developed skills (defined as children one standard deviation below the mean, based on their beginning-of-year performance). TSR uses progress monitoring to identify low performing children, who are then placed in skill-based small groups where they receive more targeted support and instruction. Compared to their peers, children with the least developed skills experience the most dramatic gains over the course of the year.

Because over 80% of Texas school districts use CLI Engage progress monitoring tools, CLI is able to track the early learning skills of approximately 280,000 children in Texas each year, providing invaluable information for educators, policymakers, and parents. Moreover, CLI has expanded its progress monitoring tools into kindergarten and first and second grade, and will soon be able to provide snapshot statewide data for children in these age groups as well.

Like TSR, PALS has been evaluated in multiple research studies that provide evidence that families and children are positively impacted by participation in the program, and PALS is listed in the U.S. Department of Education Institute of Education Sciences' *What Works Clearinghouse*. PALS is also featured in the National Home Visiting Resource Center's *Home Visiting Yearbook*, which uses data from 15 programs recognized as evidence-based to create a national profile of home visiting annually. Some key PALS outcomes for parents include richer vocabulary use, richer verbal explanations, and greater warmth and sensitivity to their children. The majority of children in PALS studies showed greater expressive language skills, higher scores on cognitive tests, and more positive affect during interaction with their parents, among other positive outcomes.

Finally, the introduction of CLI Engage resulted in significant cost-savings for publicly supported programs, as they were able to access TSR's child progress monitoring tools, professional development courses, and supplemental curricula at no cost. **To date, CLI Engage serves 1,100 communities, 8,597 schools, and 31,708 teachers across Texas.**

TSR is currently supported by funds made available through the Texas Education Code, Subchapter E, Section 29.160 (e) of Senate Bill 76 of the 78th Legislative Session, and Senate Bill 1, General Appropriations Act, Article III, Education, Texas Education Agency Rider No. 42, and Article VII, Business and Economic Development, Texas Workforce Commission Rider No. 27 of the 85th Legislative Session.

Are there new opportunities that the state could expand on at CLI to improve the health and brain development of babies and toddlers?

With CLI's intervention expertise, statewide network, and powerful technology platform, we are in an excellent position to serve greater numbers of children through scaling our innovative programs. Moreover, our extensive experience with remotely delivered interventions can be a valuable asset to state agencies as COVID-19 compels programs to look for online solutions. Below are two strategic priorities for CLI that serve our mission to advance outcomes for young children at-risk by reaching the family members who care for them.

1. *Advance a whole-child focus by complementing TSR's classroom-based services with the evidence-based parenting program,* Play and Learning Strategies *(PALS)*

   Coordinating programs across the home and school contexts, where children spend most of their time, could yield incredible benefits for children if both environments include responsive interactions, rich language, and activities that promote academic skills. This synergy becomes even more important during the COVID-19 crisis, as uncertainty about returning to traditional school operations continues and parents take on more responsibilities for educating their children at home. Looking past COVID-19, remote interventions provide unique benefits for families, including convenience and cost-savings, and are scalable to urban and rural communities alike. Virtual coaching can also offer powerful opportunities for parents to review and reflect on video recordings of their

interactions with children, promoting bonding, social-emotional skills, language, and positive behavior, to name a few.

PALS has already been adapted for remote delivery for a federally funded research study examining the impact of coordinated school and home interventions. The study found that parents were highly engaged in the remote program and that PALS improved numerous aspects of children's regulation and behavioral control. With the dissemination power of CLI Engage and the outreach network of TSR, additional appropriation funds would allow CLI to scale PALS parent coaching statewide.

In collaboration with the Cizik School of Nursing, CLI is also launching an initiative to work with young families experiencing homelessness and domestic violence. Using mobile PALS, we will conduct motivational interviewing group sessions and individual parent coaching to improve engagement, parenting skills, and child outcomes among this very vulnerable population while they are homeless.

2. *Expand specialist expertise in best practices for the professional development of the early care and education workforce, particularly in strategies around family support and engagement.*

   CLI has been successful advancing our programs statewide because we engage professionals at different levels in the community, including the specialists who provide professional development services. Increasing expertise and collaboration among specialists working in local communities is a promising and scalable approach to serving greater numbers of adults who care for vulnerable children. As discussed earlier, TSR and CLI Engage reach incredible numbers of educators and families in Texas and these programs can and do serve as jumping off points for expanding specialist training. In addition to TSR and CLI Engage, CLI manages two new initiatives that can be leveraged to advance this work:

   A. CLI was awarded funds to administer the Texas Infant-Toddler Specialist Network (ITSN) beginning in 2020. The mission of the ITSN is to bring together a statewide community of infant-toddler specialists for targeted professional development and peer-to-peer exchange in order to align goals and best practices aimed at lifting the quality of care in infant-toddler classrooms. Members of the network include Early Head Start specialists, Texas Rising Star mentors, ECI specialists, and private trainers and coaches. Additional appropriation funds would allow CLI, through the ITSN, to offer more professional developmental opportunities focused on providing support to families, including:
      a. Expanding access to PALS through a PALS coaching certification
      b. Providing support for understanding Early Childhood Intervention (ECI) and the referral process

   c. Engaging families in their children's development with broad-based family engagement strategies

B. CLI is working with state agencies to finalize the Competency-Based Micro-Credentialing System, which provides online credentialing for specialists who provide training, coaching, and assessment services in Texas. This innovative system awards "badges" when specialists demonstrate specific competencies, as evidenced by a video upload of the specialist's interactions with ECC professionals. The micro-credentialing system includes professional development modules and small-group professional learning communities (PLCs) to support specialists seeking credentials. Additional appropriations would allow CLI to develop a micro-credentialing service and complementary professional development program for specialists interested in home-based interventions and family engagement.

September 30, 2020

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The University of Texas at Austin

RE: Response to Formal Request for Information: House Appropriations – Subcommittee Article II

Interim Charge #5: *Examine state investments in the health and brain development of babies and toddlers, including Early Childhood Intervention and other early childhood programs for children in the first three years. Evaluate opportunities to boost child outcomes and achieve longer-term savings.*

The Prenatal-to-3 State Policy Roadmap is a guide created by the Prenatal-to-3 Policy Impact Center at the University of Texas at Austin. State leaders can use the Roadmap to develop and implement the most effective policies to strengthen their state's prenatal-to-3 (PN-3) system of care. This inaugural Roadmap provides baseline information on the current status of each state's PN-3 system and will be updated annually to monitor: states' progress toward adopting and fully implementing the effective policies and strategies; changes in the generosity of state benefits; progress toward serving all children and families who are eligible for state benefits; changes in the overall wellbeing of children and families in each state; and efforts to reduce racial and ethnic disparities in outcomes. Findings from the baseline analysis show that states need to strengthen their PN-3 systems of care. The science of the developing child points to eight prenatal-to-3 policy goals that all states should strive to achieve to ensure that children are born healthy to healthy parents, that parents have the skills and resources they need to be the parents their children deserve, and that when children are not with their parents, they are in high-quality, nurturing care environments.

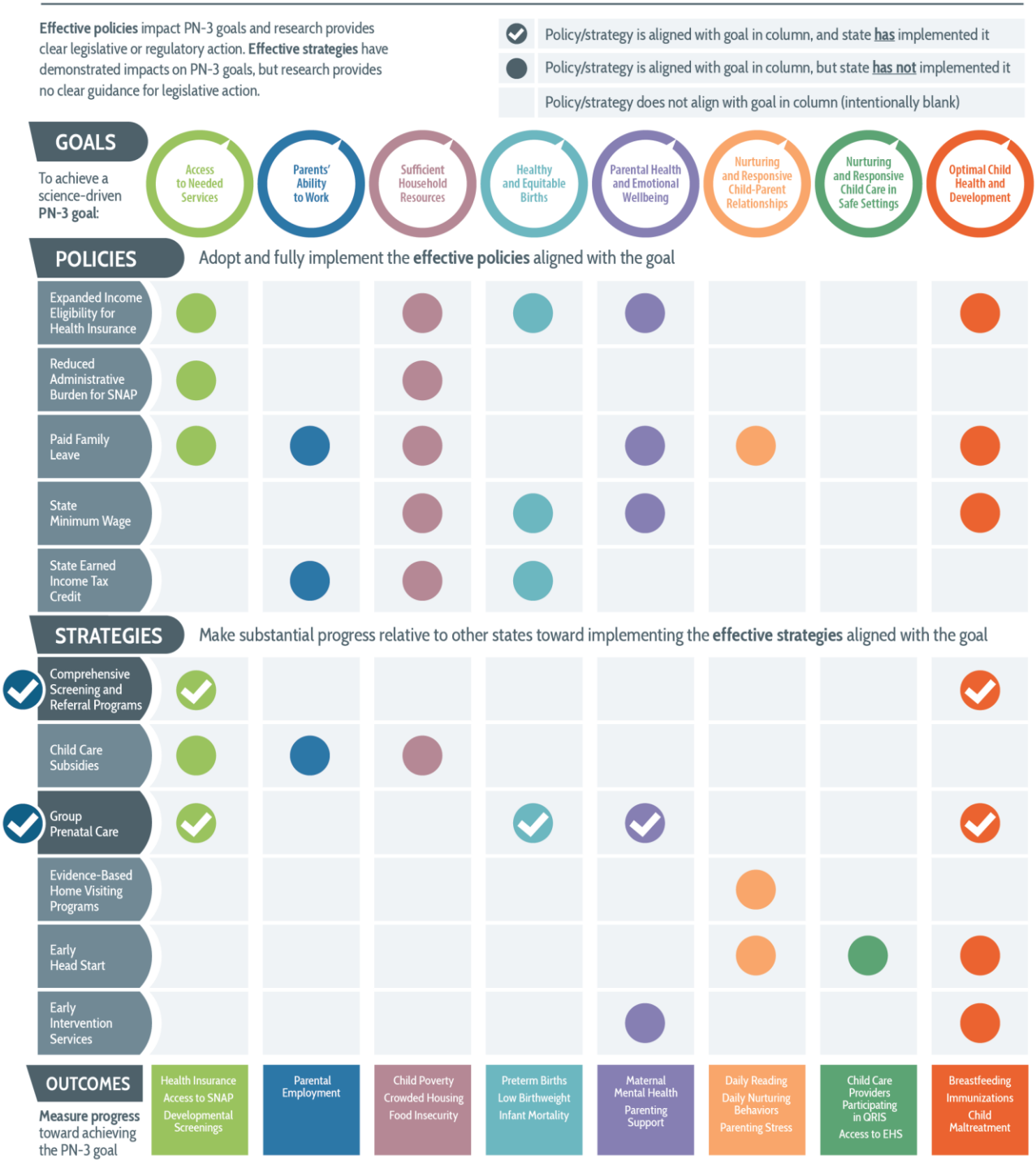
Eight Prenatal-to-3 Policy Goals

1. ***Access to Needed Services:*** *Families have access to necessary services through expanded eligibility, reduced administrative burden, and identification of needs and connection to services.*
2. ***Parents' Ability to Work:*** *Parents have the skills and incentives for employment and the resources they need to balance working and parenting*
3. ***Sufficient Household Resources:*** *Parents have the financial and material resources they need to provide for their families*
4. ***Healthy and Equitable Births:*** *Children are born healthy to healthy parents, and pregnancy experiences and birth outcomes are equitable*
5. ***Parental Health & Emotional Wellbeing****: Parents are mentally and physically healthy, with particular attention to the perinatal period*
6. ***Nurturing & Responsive Child-Parent Relationships:*** *Children experience warm, nurturing, stimulating interactions with their parents that promote healthy development*
7. ***Nurturing and Responsive Child Case in Safe Settings:*** *When children are not with their parents, they are in high-quality, nurturing, and safe environments*
8. ***Optimal Child Health & Development:*** *Children's emotional, physical, and cognitive development is on track and delays are identified and addressed early*

Through comprehensive reviews of the most rigorous evidence available, the Prenatal-to-3 Policy Impact Center identified 11 effective solutions, including five effective policies and six effective strategies positively impact at least one of these PN-3 goals and many reduce longstanding disparities in outcomes among racial and ethnic groups and socioeconomic statuses. Effective policies impact PN-3 goals and research provides clear legislative or regulatory action. Effective strategies have demonstrated impacts on PN-3 goals, but research provides no clear guidance for legislative action. Texas should strive to fully implement the 11 PN-3 solutions with the strongest evidence of effectiveness to date.

Texas's Prenatal-to-3 State Policy Roadmap

The chart illustrates how the 5 policies and 6 strategies impact the prenatal-to-3 policy goals. Each column represents a PN-3 goal. The filled circles within each column indicate the policies and strategies that impact that PN-3 goal. Filled circles with a check mark indicate that your state has implemented the effective policy or strategy. Your state should work to check all of the circles in the columns.



Policies that Texas can adopt and implement:

Expanded Income Eligibility for Health Insurance* – adopt and fully implement the Medicaid expansion under the Affordable Care Act (ACA) that includes coverage for most adults with incomes up to 138% of the federal poverty level.

- *Texas has not expanded income eligibility for Medicaid*. Legislators filed two bills in 2017, and four bills in 2019 that would expand Medicaid, but all failed.
- Texas has the highest percentage of low-income women who are uninsured in the country (47.1%).
- **Return on investment**: Evidence included in our evidence review shows that state expansions of Medicaid have improved financial wellbeing among low-income individuals and families, and these cost savings may be passed along to others as well. One study found a reduction in new incidences of unpaid medical bills after Medicaid expansion, suggesting improved financial outcomes for medical providers. This finding is in line with two studies outside the scope of this review that have found decreases in uncompensated care for hospitals since the passage of the ACA.

Reduced Administrative Burden for SNAP* – strive for a median recertification interval of 12 months or longer among households with SNAP-eligible children under age 18.

- *Texas has a median recertification interval of 6 months among households with SNAP-eligible children*, and the SNAP manual outlines 6-month recertification interval four households that are not in the following categories: able bodies without dependents (ABAWD), elderly, and with disability and unable to work. No legislation to adjust recertifications intervals was files from 2017 to 2020.
- Texas ranks 48th in the nation for % of eligible families with children under age 18 NOT receiving SNAP (19.8%).
- **Return on investment**: The studies included in the evidence review of administrative policies that affect SNAP participation did not examine the return on investment generated by the program, but other reliable sources have examined the economic impacts of SNAP and of reduced administrative burden. A 2019 report by the USDA found that states that implemented more streamlined administrative policies decreased their per-case costs. For example, adoption of policies such as broad-based categorical eligibility and simplified income reporting lowered state administrative costs by up to 14 percent (7 percent per policy). Overall, states that implemented a set of low-burden policies saw lower administrative costs than states that adopted individual policies. A correlational analysis also found that states with higher access (greater SNAP participation rates among those eligible) benefited from lower per-case administrative costs, and states with lower participation rates saw higher per-case costs. Greater SNAP participation has been found to have beneficial economic effects. For example, an analysis found that every $1 increase in SNAP benefits in 2009 (during the recession) spurred $1.70 in economic activity. SNAP benefits allow low-income families to spend earned income on other necessities besides food, further stimulating the economy and ensuring families have access to needed resources. SNAP benefits are also well-targeted to reach very low income families; research has found that 92 percent of SNAP benefits are provided to households at or below the poverty line, and 55 percent of benefits are provided to those at or below 50 percent of the poverty line. The Center on Budget and Policy Priorities reports that 97 percent of SNAP dollars are spent within a month, allowing the benefits to flow back into the economy quickly.

Paid Family Leave* - adopt and fully implement a paid family leave program of a minimum of 6 weeks following the birth, adoption, or the placement of a child into foster care.

- *Texas does not have a paid family leave program*. A search of proposed legislation from 2015 through 2020 found two bills (HB 656 in 2017 and HB 1559 in 2019) filed to provide 30 days of leave annually to care for a new child, but both failed.
- 27.5% of children under age 3 in Texas are living in a family in which NO parent has regular, full-time employment.
- **Return on investment**: Despite initial concern about the impact of the policy on employers and businesses, studies have found that most employers report “no noticeable effect” or “a positive effect” of paid family leave

on employee productivity, profitability, turnover, and morale. Some businesses have found that paid sick leave makes it more likely that employees will receive preventive health care, reducing later health care costs, but more rigorous research on the return on investment for paid *family* leave, beyond employer surveys, is needed to build the evidence base.

State Minimum Wage* – adopt and fully implement a minimum wage of $10 or greater.

- *The current minimum wage in Texas is the federal minimum of $7.25*, as designated by state statute. The federal minimum wage was last increased through enacted federal legislation in 2007 and the most recent scheduled increase was in 2009. Texas prohibits localities from establishing minimum wages for private employers that are higher than the minimum wage established by state law. Legislators filed 11 bills (HJR 56, HJR 57, HCR 73, HB 105, HB 133, SB 229, HB 285, HB 475, HB 924, HB 937, and HB 992) in 2017 and eight bills (SJR 5, SJR 22, HJR 45, SB 113, HB 194, HB 290, HB 820, and HB 1336) in 2019 that would increase the minimum wage; all failed.
- 14% of parents in Texas with children under age 3 earn less than $10 per hour.
- **Return on investment**: Two strong causal studies found that higher minimum wages boosted earned income and reduced the amount of public assistance families received. In addition, a policy brief by the Economic Policy Institute estimated that for the lowest-income workers, a $1 increase in hourly wages would reduce the likelihood of receiving public assistance by 3.1 percentage points (a reduction of 850,000 individuals). A study estimating the effects of a federal minimum wage increase from $7.25 to $9.80 (which would, by default, raise the state minimum wage for those states that use the federal floor) predicted an increase in Gross Domestic Product of $25 billion and a net increase in jobs of 100,000 over 2 years following implementation.

State Earned Income Tax Credit* – adopt and fully implement a refundable EITC of at least 10% of the federal EITC for all eligible families with any children under age 3.

- *Texas does not have a state EITC or a state income tax*. A search of proposed legislation from 2015 through 2020 found that no legislation has been proposed in Texas to create a refundable EITC.
- **Return on investment**: A 2019 study of the return on investment for the EITC (federal and state) found that the credit largely "pays for itself" by increasing taxes paid (by $92 per household) and reducing public assistance received (by $243 per household). The analysis found that "states with EITCs gain more from the federal EITC, perhaps because state EITCs independently increase labor supply" (p. 21). In 2017, low-income families received $73 billion in total EITC assistance for a net cost to the government of only $12 billion.

Strategies that Texas can implement:

Early Intervention Services* – use a moderate or broad criteria to determine eligibility and serve children who are at risk for later delays or disabilities.

- *Texas uses broad criteria to determine eligibility, but the state does not serve children who are at risk for later delays or disabilities*.
- Texas uses broad criteria to determine eligibility for early intervention services, but only 2% of all children under age 3 receiving Early Intervention services. National research suggests that the prevalence of children under age 3 with delays and disabilities who can benefit from Early Intervention services is between 13% and 20%. In 2018, Part C served 409,315 children (and their families) ages 0 to 3—3.5% of the US population under age 3.
- **Return on investment**: A recent analysis of six states found that Early Intervention services helped between 760 and 3,000 children per state to avoid special education services at age 3, with a 1-year cost avoidance of between $7.6 million to $68.2 million depending on the state. Three-year cost avoidance estimates, which accounted for children re-entering special education services after an initial exit, still projected substantial cost savings. For example, Michigan calculated a potential 3-year savings of $27.1 million even when 25 percent of children were expected to return to special education services in the second and third years tracked.

Child Care Subsidies* – set base reimbursement rates (for infants and toddlers in center-based care and family child care) at the federally recommended 75th percentile using a recent market rate survey.

- *The base reimbursement rates in the Gulf Coast LWDA do not meet the federally recommended 75th percentile, but the state does use a recent (>2 years) market rate survey to set rates.*
- The base reimbursement rates in the Gulf Coast LWDA (the most populous geographic region in a state) do not meet the federally recommended 75th percentile, but the state does use a recent (>2 years) market rate survey to set rates.
- **Return on investment**: None of the strong causal studies included in the evidence review directly assess the return on investment or cost savings as a result of subsidy receipt or subsidy policies. However, studies that find positive impacts of subsidy receipt and policies on maternal employment, weekly number of hours worked, and maternal education may suggest positive economic returns.

Evidence-Based Home Visiting Programs* - supplement federal funding for home visiting programs, and serve eligible children by evidence-based home visiting programs.

- *Texas supplements federal funding, but the estimated percent of eligible children served by home visiting is below the median state value (7.3%)*.
- While Texas supplements federal funding for home visiting, only an estimated 2% of eligible children under age 3 are served by evidence-based home visiting programs.
- **Return on investment**: A 2017 report, as part of the Mother and Infant Home Visiting Program Evaluation (MIHOPE), examined the lifetime return on investment for Healthy Families America (HFA), the Nurse-Family Partnership (NFP), and Parents as Teachers (PAT). The study projected that long-term benefits are 25 percent greater than costs in HFA, 88 percent greater than costs in NFP, and 244 percent greater than costs in PAT. Benefits of the NFP program were greatest for single mothers with low income, with each $1 spent producing over $5 in benefits for this group, compared to $1.10 in benefits for other families. The authors explained that lifetime benefits typically accrue in the form of increased earnings for both mothers and their children through reduced child maltreatment, better academic achievement among children, and better high school graduation rates among mothers.

Early Head Start* - supplement federal funding for Early Head Start (EHS), and serve income-eligible children by EHS.

- *Texas does not supplement federal funding, and the estimated percent of income-eligible children with access to EHS is below the median state value (8.9%).*
- An estimated 4% of income-eligible children under age 3 have access to Early Head Start in Texas.
- **Return on investment:** None of the strong causal studies included in this review directly assess return on investment or cost savings as a result of EHS participation. Data on the cost of EHS are limited: in 2014-15, the national average federal funding per child in EHS was $12,575 (adjusted for cost of living). These cost figures vary widely by state and do not include grantee cost-sharing spending.

As the evidence base grows and more information becomes available, the list of effective policies and strategies will expand, and additional information on the return on investment of each effective solution will be provided.

**Policy/strategy has the potential to impact a broad range of prenatal-to-3 goals.*

Links to resources with more detailed information:

Explore State Data Interactives for Texas here, and access Texas' full Roadmap here.
For the complete PN3 Roadmap, click here.
For more information about evidence reviews of policies/strategies, visit the PN3 Policy Clearinghouse here.
Contact exchange@pn3policy.org to discuss how the PN3 Policy Impact Center can best serve as resource in Texas.

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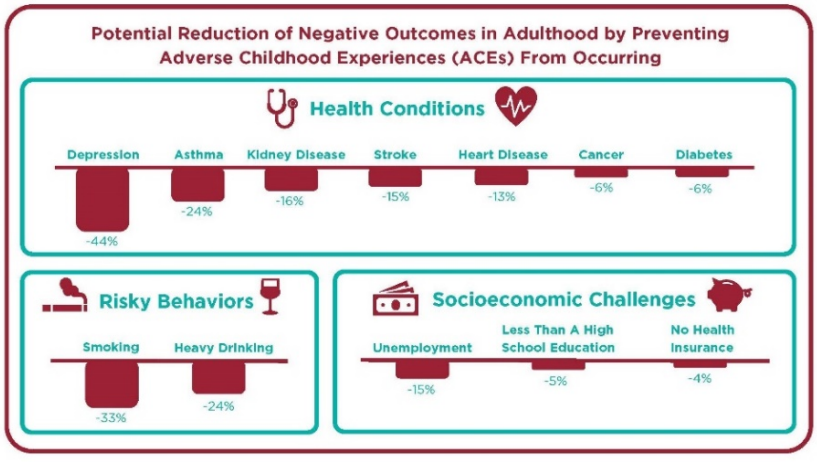
Input to Appropriations/Subcommittee on Article 2 - 2020

Interim Charge #5: Examine state investments in the health and brain development of babies and toddlers, including Early Childhood Intervention and other early childhood programs for children in the first three years. Evaluate opportunities to boost child outcomes and achieve longer-term savings.

Children are born with an amazing capacity to learn and grow. Per second, 700 to 1,000 new neural connections are created in the infant brain. 90% of brain development happens before age 5. However, development does not happen in isolation. It is dependent upon responsive relationships and engagement with a stimulating environment. Like building a house, early experiences will create a strong or unsteady foundation for everything that comes later.

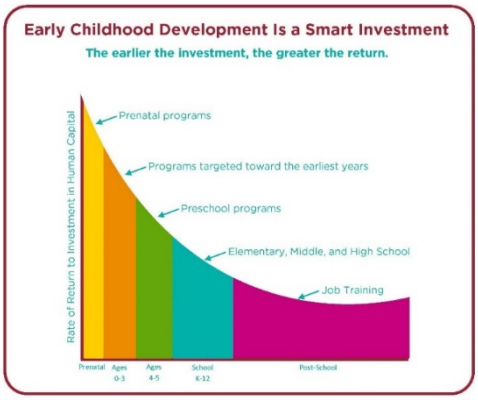
Brain architecture is dependent upon the experiences a child has or does not have. Of primary importance is their connection to a safe, stable, and responsive caregiver. This is the *how* of Early Childhood Brain Development (ECBD). A child learns about the world and how to engage one interaction at a time. When a baby reaches out and does not get a response or gets a negative response, they are learning which skills are important to strengthen and which are not. They may learn that they cannot depend on their caregiver and environment or that they are not safe. Alternatively, when a baby reaches out and is met with a healthy response, they access the safety, security, and connection that is needed to enable higher-level cognitive skills as well as social-emotional development.

Stress is a natural part of life, but chronic and uncontrollable stress is toxic. The biology of stress is intended to be short-term and can be calmed in safe environments and dependable relationships. When children experience chronic adversity and trauma, the neurological and hormonal impacts can alter brain development and biology in ways that have outcomes across the lifespan including mental and physical health.



The immense research done on the health implications of Adverse Childhood Experiences (ACEs)[i]—including abuse, neglect, family violence, or growing up with a caregiver who is incarcerated, mentally ill, or engaging in substance use—makes clear that what happens in early childhood literally lasts a lifetime. The prevention of ACEs holds incredible potential for ensuring healthy development and impacting societal challenges and taxpayer costs across multiple domains.

To create the most effective and efficient systemic change, interventions should occur in early childhood. Nobel Laureate and economist, James Heckman's, work[ii] makes an economic case for early childhood investments that begin before birth. Model early childhood programs offer a return between $3 and $9 per dollar invested and are much cheaper than interventions that work to address problems in our educational, criminal justice, and healthcare systems. Comprehensive supports for children and their families result in better outcomes for children and better economic returns than any one element alone. And in general, the earlier the better.



The cost of inaction is clear. ACEs are associated with negative outcomes for individuals across the lifespan including poorer health, lower educational attainment, and higher likelihood of experiencing unemployment. Individuals and governments incur significant costs as a result. Bellis et al. (2019) estimate that annual healthcare costs attributable to ACEs across North America are approximately $748 billion with 82% of costs resulting from individuals who had two or more ACEs.[iii] With one in 10 American children living in Texas we can expect to incur a significant percent of those costs if we aren't better able to prevent ACEs.

Health care costs as a result of ACEs are the most well-documented, but there are also criminal justice, child welfare, education costs, among others. For example, each case of child abuse or neglect causes $830,000 dollars in costs across the victim's lifetime.[iv] This translates to over $55 billion dollars in costs resulting from confirmed abuse and neglect in Texas in 2019 alone. We can continue to pay for the effects of childhood adversity, or we can work to prevent it.

Recent data from the Child and Family Research Partnership at the University of Texas' Prenatal to Three Policy Impact Center suggests that Texas has a long way to go in ensuring that children and families are well supported and healthy.

Outcome measure	Texas Rate	Texas Rank among 51 States
Children < 3 in poverty	22.3%	38
Low income women uninsured	47.4%	51
Children < 3 NOT receiving developmental screening	58.9%	21
Poor maternal mental health	4.9%	29
Low parenting support	22%	47
Children not read to daily	71.1%	48
Children not nurtured daily	52.4%	51
Parents not coping very well	25.4%	10
Children < 3 not fully immunized	27.7%	28
Maltreatment rate per 1000 children < age 3	18.4%	29

Source: Texas Prenatal to Three State Policy Roadmap/Prenatal to 3 Policy Impact Center

As all of these rates were reported before COVID-19, we have reason to believe that on most of these measures we would see dramatic increases with more current numbers. TexProtects worked with Child Trends to look specifically at the potential impact of COVID-19 on child abuse and neglect risks and found reason to believe that increases in unemployment, mental health struggles, family violence, substance use issues, and parental stress may result in increased abuse and neglect. Research during

the last recession found that **for each point the unemployment rate rises, physical and emotional abuse increase by 12-15%.**[v]

However, with the large majority of CPS cases addressing neglect rather than abuse and much abuse/neglect going unreported, we know families need support more often than they need protection. The most cost-efficient and effective approaches offer supports **before a crisis occurs** and during the first years of life when a stable, safe, nurturing caregiver is **the key** to healthy child development.

TexProtects serves as a steering committee member of the Texas Prenatal-to-Three (PN-3) Collaborative, a group of 100+ organizations around the state who have worked together to identify feasible and effective strategies to ensure over 300,000 more infants and toddlers have access to needed supports by 2026. To achieve that mission, the PN-3 Collaborative is focusing on an agenda for Texas that includes legislative, regulatory, and community work that increases access to healthy beginnings, family support, and quality early care and education.

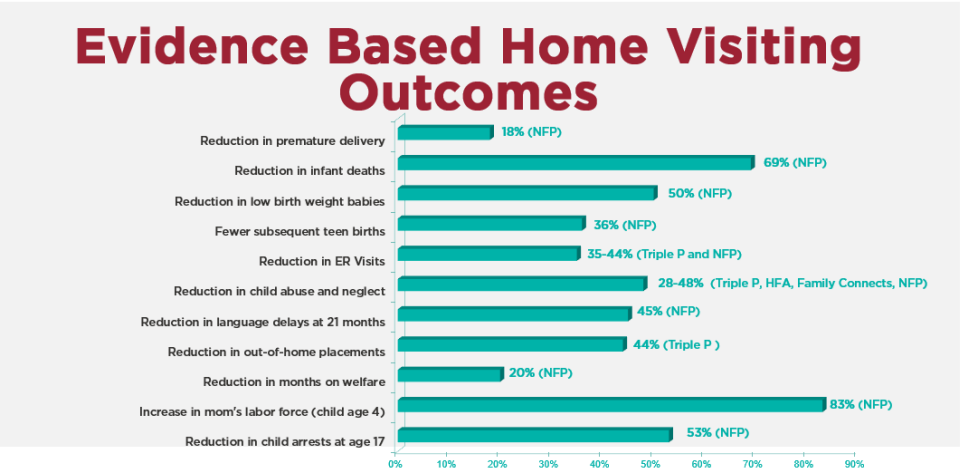
As the statewide leader for the **family support** section of that agenda as well as long time champions for effective and cost-efficient prevention programs that support children and families, TexProtects would forward the following recommendations to the committee:

Recommendations

1. **Fully fund the Prevention and Early Intervention Exceptional Item Request to strengthen community-based, primary child abuse prevention programs for children prenatal to age 5 through Healthy Outcomes Through Prevention and Early Support (Project HOPES) and Texas Nurse-Family Partnership (TNFP).**
   C.1.4 & C.1.5

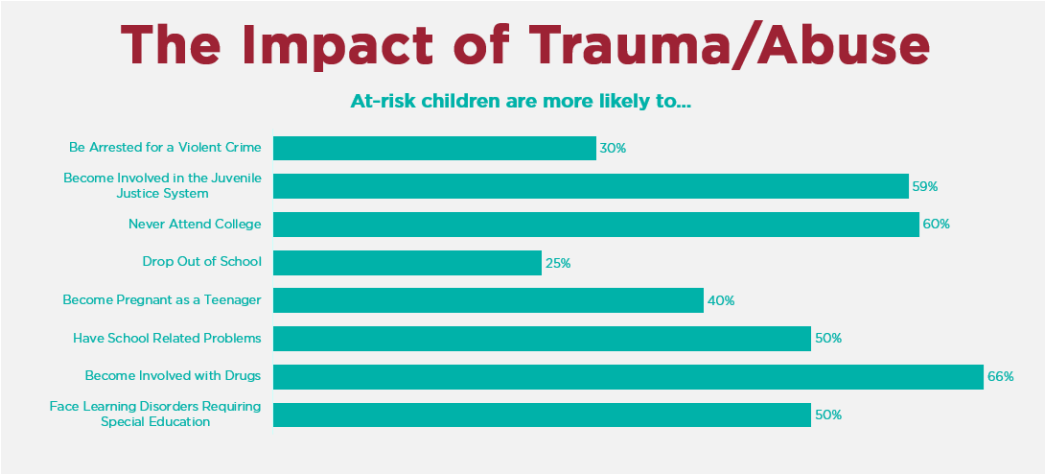
Proven prevention programs administered through the Prevention and Early Intervention Division at DFPS have been critical lifelines for families during COVID-19 and depend on an infrastructure of community providers who work together to support families. Over the past decade, state and federal investments have helped build a prevention infrastructure facilitated through state grants to local communities that is a model for states around the country.

These prevention programs largely provide evidence-based home visiting and wrap-around services to families facing challenges. There are several models; however, they all share an approach in that they are 100% voluntary and provide parenting support, child development information, screenings, and referrals to families. These programs have a proven return on investment of between $1.26 and $8.08 and have impacts across multiple domains and two generations. [vi]



With only 4% of the families in highest need with current access, expansion is critical if Texas desires the statewide impact and cost savings that could result from widespread access to these programs. The current PEI strategic plan indicates that to adequately protect families, a 20% increase in prevention funds is needed every biennium. Currently, DFPS only spends 5% on early prevention efforts compared to CPS costs.

Historically, prevention funding has faced cuts during recession. This is a mistake. Any cut would put children at risk while also negatively impacting local providers and their employees who depend on the state grants to provide services. Ultimately, cuts to prevention would result in increased costs in our education, child welfare, health, and criminal justice systems for years to come.[vii]



As noted by the *DFPS 2018 Prevention Task Force Report,* "Diverting 5% of families from Family Based Safety Services (1786) would save the state more than $9.4 million. Preventing 3% of removals (593) would save upwards of $20.3 million."

2. Expand Universal Prevention Strategies in Public Health Settings

Healthcare settings remain one of the most universal touchpoints for families with young children and provide an opportunity to connect with families during a critical and sensitive period for child development. Innovative programs are working within public health settings to provide more holistic supports to families and create a more efficient mechanism for resource and referral work in communities. One innovative program currently operating in Texas is **Family Connects**. This model begins by offering moms, while they are in the hospital following a birth, a free home visit by a registered nurse three weeks postpartum. Over 85% of those offered the program accept. At the visit, the nurse completes health and mental health screenings on the mom and baby, shares information, and connects the family to other community supports as needed. Follow-up is provided to every family within six weeks to ensure connections were made and to see if additional support is needed. **The program has shown a $3.02 return on every dollar investment in emergency room costs alone. It also impacts maternal mental health, positive parenting behaviors, and has shown a 39% reduction in child abuse investigations even 5 years after services end.** The program is currently operating in five counties around Texas with a mix of federal and state funds administered through the Prevention and Early Intervention Division at DFPS (C.1.4 & C.1.5) as well as local philanthropic and Medicaid Managed Care Organization investments. Innovative funding mechanisms including alternative payment methods for MCOs could further expand these programs around Texas in ways that are cost effective now and later.

3. **Prevent early childhood trauma and entries into foster care by leveraging the opportunities in the Federal First Prevention Services Act to offer families at imminent risk of removal access to evidence-based mental health, substance use, and parenting supports.**

Texas must be proactive and innovative in determining how to maximize the opportunity of the Family First Prevention Services Act to access federal matching funds for prevention funding that can be used to directly address the key drivers of child abuse/neglect: substance use, mental health challenges, and poor parenting skills. 55% of confirmed victims are under age 5, so family supports are critical for families at risk who have young children. Use of these funds should be prioritized for evidence-based programs that will prevent entry into the foster care system as this is the primary way to ensure better outcomes for children, family preservation, and long-term cost savings for the state. The current plan provided by the state invests $33.9 of the $50.4 million federal transition funds toward prevention but does not provide a vision for state investments across the Article 2 budget that could help Texas draw down the federal match and expand access to services. We recommend the 87th legislature ensure there is budgetary infrastructure to support future state investments. We provided more comprehensive comment on FFPSA in separate comments to your committee.

4. **Support additional Prenatal to Three Collaborative Agenda items including strengthening Early Childhood Intervention, enhancing maternal health by extending Medicaid to 12 months postpartum & connecting infants and toddlers to health care through continuous, 12-month coverage in Children's Medicaid.**

Given the social isolation and increasing stress and risks for families due to COVID-19, the work of strengthening families and ensuring child safety must begin before a crisis occurs. While mitigating the health effects of the virus is primary, these longer-term risks will continue to affect our children's and our state's future for years to come. As such, investment in the front end of the system and in our youngest children is needed now more than ever. Thank you for your dedication to this critical issue and for your continued work to ensure healthy beginnings for our state's most important resource, our children.

[i] *Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998).*
[ii] *www.heckmanequation.org*
[iii] *Bellis et al (2019)*
[iv] *Peterson et al (2018)*
[v] *Schneider, W., Waldfogel, J., & Brooks-Gunn, J. (2017).*
[vi] *: Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009); Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). DuMont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., Rodriguez, M., & Dorabawila, V. (2008); Olds, D. L., Kitzman, H. J., Cole, R. E., Hanks, C. A., Arcoleo, K. J., Anson, E. A., . . . Stevenson, A. J. (2010); Olds, D. L., Kitzman, H., Hanks, C., Cole, R., Anson, E., Sidora-Arcoleo, K., et al. (2007); Olds, D. L., Robinson, J., Pettitt, L. M., Luckey, D. W., Holmberg, J., Ng, R. K., . . . Henerson, C. R. (2004)*
[vii] *Barnett, W.S., & Masse, L.N. (2002).; Swan, N. (1998).; Campbell, F. A., et al. (2002).; Widom, C., & Maxfield, M. (2001).*

September 30, 2020

Response to Request for Information: Interim Charges #1, 2 & 5
Appropriations - S/C on Article II

Chair Davis and Article II Committee Members,

On behalf of Protect TX Fragile Kids and the thousands of Texas families whom we represent and advocate for, below please find a brief submission in response to the Committee's request for information. We appreciate the opportunity to share our experiences and concerns related to Interim Charges #1, 2, and 5, and would be happy to answer any questions or provide any additional information as needed.

Interim Charges #1 & 2

In 2019, the 86th legislature passed SB1207, SB1096, and HB4533 to put in place some patient-focused measures designed to provide targeted improvements to Medicaid managed care programs, with the intent of building upon these measures going forward by instructing the Texas Health & Human Services Agency to study and report alternative models of care more appropriate for certain high-needs populations. These much needed short-term measures were developed by legislators, with full agreement and involvement from the agency, to help bring some transparency to an opaque and burdensome process, and to address dangerous shortcomings and emergent issues that continue to cause significant delays and denials of life-sustaining care, including difficulties with access to care and network adequacy issues for vulnerable Texans who rely upon Medicaid to live in the community, at considerable cost savings to the state versus an institution.

You may recall that some of these issues had been publicized by news coverage, such as the investigative reporting series "Pain & Profit" published by The Dallas Morning News. Others were addressed in detailed reports by the Legislative Budget Board, and extensive public testimony from individuals, family members, and providers further illustrated the many alarming issues and blatant conflicts of interests rooted in profitability for insurance companies associated with the managed care model, who are incentivized to deny critical services. Although there is still much work to be done, the legislative measures passed last session were designed to be patient-focused and help to provide some much-needed relief and improvement for Texans with disabilities.

Yet more than a year after the legislation went into effect, for the most part, no plan, rules, or process has been promulgated by HHSC to implement the legislative changes and mandates outlined in these bills and provide relief to Texans struggling under this inappropriate and ineffective model. We appreciate that HHSC verbally advised the STAR Kids Advisory Committee last week that they had made

progress in addressing two components of SB1207; however, no information has been forthcoming on any of the other provisions required by the remainder of SB1207, nor regarding SB1096 or HB4533. Meanwhile, patients continue to experience life-threatening denials, and numerous other bureaucratic challenges in accessing vital care such as critical prescription medications and authorization for basic supplies; while the limited pediatric specialty providers in the state are further burdened by onerous red tape and administrative requirements, and are pressured by the managed care organizations to agree to drastic rate cuts despite razor thin-margins, and contracts that are unsustainable and directly affect services for those who have the highest level of need. This further contributes to the inadequate network, and further decimates the already limited pediatric specialty care industry in Texas.

Oversight from the agency tasked by the legislature with managing these insurance companies who are state contractors seems nonexistent, and legislative direction and clear intent seems to be disregarded, begging the question of who is in charge: the agency or the legislature.

We urge the committee to carefully consider the need for accountability and increased legislative and state oversight for the agency and these state contracted insurance companies who are tasked with utilizing appropriated tax dollars to ensure effective and appropriate use of these tax dollars as intended to care for our state's most vulnerable citizens, and believe this is something that must be further addressed in the upcoming legislative session.

Further, we would request that the Committee consider the increased Money Follows the Person federal funding which has been made available to Texas to continue the MFP program, and to provide additional emergency diversion slots for Texans in crisis to avoid institutionalization and remain at home and in their communities.

As we have stated previously, with disruption comes opportunity, and we know that Texas can do better for Texans with disabilities than our current ranking as 49th in the country. As our state faces potential budgetary changes which may affect Texas' healthcare programs, including the 1115 waivers, we urge the Committee to consider not only the moral implications, but also the enormous cost savings to the state by fully funding home and community-based (HCBS) waiver programs, and keeping Texans with disabilities from being institutionalized. Cuts to these programs are short-sighted, and only cost the state more in the long-term.

Further, we believe that there is an opportunity for Texas to lead and be innovative in this area by working to identify an effective and appropriate model for this population that while a small population, accounts for a significant percentage of Medicaid costs due to the complexity and extensiveness of needs. The federal ACE kids act offers possibilities for federal funding to pilot and develop innovative alternative models of care for a certain segment of this complex population of children, and the timing is fortuitous. This aligns with the directive to HHSC in HB4533 to study possible alternative models of care for children with disabilities, and could be a gateway to not only future significant improvements to the Texas Medicaid Program, but also to provide longer-term cost savings to the state by developing and implementing a more effective and appropriate model of care that is better suited to the needs of this

group. Primary care and preventative medicine have very different meanings for Texans who live with disabilities and complex medical needs. We believe that Texas can and must do better, and should lead the way in caring for our most vulnerable, and would love to set up a time to discuss some of these ideas and opportunities with you.

Interim Charge #5

It is impossible to underestimate the critical importance of fully funding early childhood intervention and making it available to little Texans with big needs.

Fully funded and fully available to children who are born prematurely or with disabilities, the relatively small investment in early childhood intervention pays dividends not only in reducing the exponential costs for treatment, which rise dramatically as the child grows older and the brain becomes less elastic, but also in bringing enormous hope and connection to resources for the families struggling to know how to care for their child. The longer intervention is delayed, the more extensive the intervention will need to be, and still may not provide the same outcomes or improvements that could have been achieved with early intervention. By providing access to a little help early in the life of a child at risk, in the overwhelming majority of cases, early intervention helps to provide early diagnosis, and prevent or lessen further regression and developmental delays, resulting in significantly better outcomes and often less future intervention required for the child, the family, and ultimately the state.

As a state, we all win when Texas invests in our most valuable resource: our children.

Interim Charge #5: Examine state investments in the health and brain development of babies and toddlers, including Early Childhood Intervention and other early childhood programs for children in the first three years. Evaluate opportunities to boost child outcomes and achieve longer-term savings.

TEXANS CARE for CHILDREN

September 2020

Steps to Support Early Brain Development for Infants and Toddlers

Response to House Appropriations Article II Subcommittee - Charge #5

Background

Brain science is clear that infants' and toddlers' experiences are the foundation of the rest of their lives. During this unparalleled time of development, the early experiences and relationships a child has with parents and caregivers influence how a child masters new skills like walking, language, cognitive skills, and social interactions.

These early childhood experiences are shaped in significant ways by state policies and programs. When these state policies fall short, they hurt infants and toddlers of all backgrounds — but they often fall hardest on Black children. Infant mortality rates, for example, are too high for all racial and ethnic groups in Texas, but Black infants in Texas are twice as likely to die during the first year of life compared to White and Hispanic babies.[1] Experts point to several causes for these disparities, including implicit bias in the health care system; the physical toll of stress (including stress related to racism) on health and pregnancies; the way current and past discrimination affects Social Determinants of Health such as housing, education, and employment; and lack of access to health insurance.

The coronavirus pandemic and recession have disrupted many of the experiences and supports that children rely on and added greater urgency to these policy priorities. Due to the pandemic, infants and toddlers are missing check-ups that they need for immunizations, screenings for disabilities and developmental delays, and other needs. Instead of nurturing experiences in high quality child care, many infants and toddlers are now home with stressed out parents trying to work full-time jobs while taking care of their kids. Texas families are losing health insurance as they lose their jobs. Delivery of services — from ECI to CPS services — is often disrupted.

Infants and toddlers can't put this stage of early brain development on hold until after the pandemic — so policymakers can't put it on hold either. We encourage Texas policymakers to prioritize these policies during the pandemic and next legislative session.

Children's Health

Texas has the highest uninsured rate in the US — and it's getting even worse during the pandemic. Before the pandemic, Texas already had the nation's worst uninsured rate for children, adults, and women of childbearing age. In Texas, the children's uninsured rates for White, Black, Hispanic, Native American, and Asian children are ALL higher than the national uninsured rate for children. Babies and toddlers need health insurance so their parents can consistently take them to check-ups, where babies get needed immunizations and developmental screenings, and parents receive critical support and guidance provided by pediatricians and family physicians.

Policy Recommendations:

- Connect infants and toddlers to health care by ending error-prone mid-year eligibility reviews in Children's Medicaid and establishing continuous 12-month coverage.
- Protect the state budget for Medicaid and CHIP health insurance and maintain eligibility, benefits, and provider rates.
- Restore state outreach and enrollment efforts to help children enroll in and access Medicaid and CHIP.
- Accept federal Medicaid expansion funding to provide an insurance option to 2.2 million uninsured low-wage Texas adults. In addition to covering adults, Medicaid expansion has been shown to indirectly decrease the children's uninsured rate by connecting more families with health coverage.

Maternal and Infant Health

Healthy children start with healthy pregnancies, healthy births, and healthy mothers. Unfortunately, maternal deaths and pregnancy complications remain a significant concern in Texas, resulting in tragedy and long-term health issues for many mothers and children and higher financial costs for the state. In Texas, 1 in 10 babies are born premature (10.8%) and 1 in 12 Texas babies are born at an unhealthy low birth weight (8.5%).[2] These rates have been higher than the national average for the last decade. Over the first year of life, HHSC estimates that a premature baby will cost Texas Medicaid an average of $100,000, while a full term baby costs just $572.[3]

Women's lack of access to health care — before pregnancy, during the first trimester, and after pregnancy — contributes to the maternal and infant health challenges described above. Texas is one of the only states where Medicaid health insurance is typically not available to women with jobs below the poverty line, except during their pregnancy and 60 days after childbirth. Prior to the coronavirus pandemic, 1 in 4 Texas women of reproductive age was uninsured.[4] Texas has important health programs for women, but there are big gaps that significantly limit women's access to health care.

Policy Recommendations:

- Extend Medicaid coverage for new mothers from 60 days to one year postpartum, as recommended by Texas' Maternal Mortality & Morbidity Review Committee.

- Protect the state budget for Medicaid and CHIP health insurance and maintain eligibility, benefits, and provider rates. Maintain funding levels for Healthy Texas Women and Family Planning Program, which saves the state money and helps Texas women get preventive care for healthy, planned pregnancies.
- Maintain funding levels for the Department of State Health Services' (DSHS) maternal and child health division, including funding for *TexasAIM* initiative and Texas' Maternal Mortality Review Committee.
- As HHSC implements a new postpartum care package in "Healthy Texas Women+" in FY 2021, the Legislature should continue funding needed in future years so new mothers can continue to receive postpartum care via HTW+.
- Promote group prenatal and well-child care innovations — such as CenteringPregnancy and CenteringParenting — that have proven, lasting benefits for mothers, infants, and toddlers.
- Support comprehensive health coverage for low-wage Texas adults.

Early Childhood Intervention

Early Childhood Intervention (ECI) is an effective federal-state program that contracts with community organizations, such as Easterseals and Any Baby Can, to provide life-changing therapies to children under age three with autism, speech delays, Down syndrome, and other disabilities and developmental delays. By serving children during the critical first three years of life, a time of rapid brain development, ECI is highly effective in helping children learn to walk, communicate with their families, get ready to start school, or meet other goals.

Over the last decade, state leaders cut ECI funding, Medicaid reimbursement rates for therapy providers, and eligibility. Multiple programs closed amid this financial pressure. Despite an increase in state ECI funding during the 2019 legislative session, funding per child enrolled in ECI still has not been restored to prior levels, and programs are still struggling to serve all of the children who need ECI services due to staffing and funding shortages.

Policy Recommendations:

- Restore ECI funding to the 2013 funding level of $484 per child each month — accounting for projected caseload growth amid the state's growing child population — to give contractors the capacity to enroll and serve all eligible children in their communities.
- Increase funding for Child Find to support community awareness and outreach efforts to ensure all eligible children are identified, screened, evaluated, and enrolled in ECI.
- Ensure state-regulated private health insurance plans cover and reimburse for critical ECI therapies and services, including Specialized Skills Training and Targeted Case Management (SST and TCM).[5] [6]
- Evaluate and address the causes of the disproportionate under-enrollment of Black children in ECI with input from Black families as well as researchers, health leaders, early educators, and community organizations working with Black families.
- Through a CHIP state plan amendment, add Specialized Skills Training (SST) and Targeted Case Management (TCM) as covered services in CHIP.

Prevention and Early Intervention (PEI)

Through the DFPS PEI programs, Texas invests in evidence-based community programs that help reduce child abuse and neglect, build parenting skills, and improve health and educational outcomes for children. Texas PEI includes several programs to support families with young children during their critical years of brain development, including Healthy Outcomes through Prevention and Early Support (HOPES), Helping through Intervention and Prevention (HIP), Texas Home Visiting , and the Texas Nurse Family Partnership.

Policy Recommendation:

- Increase funding for primary prevention programs through PEI to prevent child abuse and neglect, strengthen and support families, increase connections to community resources.

Child Welfare

Almost half (45%) of children who enter foster care and over one-third (36%) of the children receiving family preservation services through Child Protective Services (CPS) are three years old or younger. In Texas in 2019, the lives and experiences of nearly 35,000 infants and toddlers were shaped by CPS, and CPS either paid for or connected them and their caregivers with services and supports. The 2018 Family First Prevention Services Act (FFPSA) presents opportunities for the state to do more for these young children and their families or other caregivers.

Policy Recommendation:

- **Identify early childhood programs or services for the state's proposal to the federal government for drawing down child welfare funding under the FFPSA (i.e., the "Texas IV-E plan") .** The state's current planning efforts appear to be focused on services for parents, but many evidence-based practices for both children at risk of entering foster care and their caregivers could be funded with IV-E dollars, if included in the state's plan. For example, the state could use IV-E funding to expand home visiting programs in Texas. Identifying more programs or services that will meet the federal criteria for reimbursement and support early brain development and infant and toddler mental health will be critical.

Access to Quality Child Care

Child care — and our state's policies on child care — are critical to rebuilding our economy, protecting public health, and giving infants and toddlers a strong foundation during the critical early years of brain development. With recent breakthroughs in brain science, we now know that the number of words a child hears before age three, for example, can dramatically improve their school readiness. Young children's environments during their first few years have a dramatic impact on how their brain is wired for the rest of their lives. Access to quality child care ensures that infants, toddlers, and other young children have access to care that is nurturing, attentive,

effective, and safe. The COVID-19 pandemic has exposed a longstanding truth: child care is one of the most critical industries for our state's employers, families, and children's health and education. The rapid spread of the coronavirus has put this already vulnerable industry into a tailspin that could end Texas child care as we know it. Many child care providers have closed, with many more on the brink. Even with critical steps taken by TWC to limit the damage, over 25,000 working families are on a waitlist to receive care[7].

Policy Recommendation:

- **Leverage federal funding and other available resources to ensure quality child care providers can continue to serve the children of low-wage Texans.** The Texas Workforce Commission has taken critical short-term steps to allocate federal relief funds to support child care for COVID-19 essential workers, offset lost Parent Share of Cost payments from families accepting child care subsidies, and increase reimbursement rates for those providers who take subsidies. Unfortunately, these steps are not enough to ensure that quality child care programs can endure through this crisis. The state should allocate available funding, including future federal relief dollars, to provide direct funding to quality child care providers to help them financially survive the pandemic.

Endnotes

1. Texas Department of State Health Services. 2019 Healthy Texas Mothers & Babies Data Book. (Nov. 2019).
2. Texas Department of State Health Services. 2019 Healthy Texas Mothers & Babies Data Book. (Nov. 2019). Available at https://www.dshs.texas.gov/healthytexasbabies/Documents/HTMB-Data-Book-2019-20200206.pdf.
3. French L, and Delgado E. *Presentation to the House Committee on Public Health: Better Birth Outcomes*. Health and Human Services Commission. May 19, 2016.
4. Searing, A., & Ross, D. C. Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies. Center for Children and Families. Appendix B. (May 2019). Available at: https://ccf.georgetown.edu/2019/05/09/medicaid-expansion-fills-gaps-in-maternal-health-coverage-leading-to-healthier-mothers-and-babies/.
5. Early Childhood Intervention Services Implementation Plan on Maximizing Funding (March 2020) https://hhs.texas.gov/reports/2020/03/early-childhood-intervention-services-implementation-plan-maximizing-funding-progress-report. Twenty-seven states collect private insurance as a funding source for ECI.
6. Texans Care for Children email exchange with Early Childhood Technical Assistance Center - *12 states with state statutes requiring insurance coverage for early intervention services: CT, CO, DC, FL, IL, IN, KY, MA, MO, NH, RI & VA*
7. Texas Workforce Commission (2020). Child Care & Early Learning Adobe. https://documentcloud.adobe.com/link/review?uri=urn:aaid:scds:US:113fac9d-b879-47a3-94bd-a9ef131be4dc

The National Association of Social Workers – Texas Chapter (NASW/TX) appreciates the opportunity to provide the House Appropriations Article II Committee feedback in preparation of the 2021 legislative session. NASW/TX represents over 5,000 social workers across the state and advocates for the wellbeing of all Texans. Please consider the following recommendations.

For additional information or questions, please contact Alison Mohr Boleware, LMSW, Government Relations Director at aboleware.naswtx@socialworkers.org or the NASW/TX office at 512-474-1454.
810 W. 11th St., Austin, TX 78701

Interim Charge #5: Examine state investments in the health and brain development of babies and toddlers, including Early Childhood Intervention and other early childhood programs for children in the first three years. Evaluate opportunities to boost child outcomes and achieve longer-term savings.

The Committee should strongly consider statewide Medicaid expansion to connect more babies, toddlers, and their families with comprehensive health coverage.
Brain science is clear that infants' and toddlers' experiences are the foundation of the rest of their lives. The earliest months and years of a child's life are a time of rapid physical, social, and emotional development. A baby's brain forms more than one million new neural connections every second.

The coronavirus pandemic and recession have disrupted many of the experiences and supports that children rely on. Due to the pandemic, infants and toddlers are missing check-ups that they need for immunizations, screenings for disabilities and developmental delays, and other needs. Instead of nurturing experiences in high quality child care, many infants and toddlers are now home with stressed out parents trying to work full-time jobs while taking care of their kids. Texas families are losing health insurance as they lose their jobs. Delivery of services — from ECI to CPS services — is often disrupted.

Medicaid expansion would provide an insurance option to 1.5 million uninsured low-wage Texas adults, according to pre-pandemic estimates. In addition to covering adults, Medicaid expansion has been shown to indirectly decrease the children's uninsured rate by connecting more families with health coverage.

Other policy steps to recommend beyond Medicaid Expansion:

- 12-month continuous eligibility for children with Medicaid
- Protect the state budget for Medicaid and CHIP health insurance and maintain eligibility, benefits, and provider rates.
- Funding for outreach and enrollment
- Full funding for Early Childhood Intervention - The state's ECI program is very effective helping toddlers with disabilities and developmental delays communicate with their families, learn to walk, get ready to attend school, or meet other developmental goals. However, children who need the services face several obstacles to enrolling, including challenges related to coronavirus and a continued lag in state funding per child.
- Child care — and our state's policies on child care — are critical to rebuilding our economy, protecting public health, and giving infants and toddlers a strong foundation during the critical early years of brain development
- Funding for Prevention and Early Intervention services
- Extend Medicaid coverage for new mothers from 60 days to one year postpartum, as recommended by Texas' Maternal Mortality & Morbidity Review Committee. Promote group prenatal and well-child care innovations — such as CenteringPregnancy and CenteringParenting — that have proven, lasting benefits for mothers, infants, and toddlers.

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SEPTEMBER 30, 2020

Response to Formal Request for Information by the House Appropriations Committee, Article II

Interim Charge #1: Medicaid Cost Containment Efforts

The Texas legislature has consistently asked HHSC to implement cost containment efforts in the Texas Medicaid program. This has led to a lower monthly spending per-enrollee today than was spent in 2002 when adjusted for inflation. While we appreciate the legislature's attempt to exclude direct client services from these cuts, as an organization that serves families at the community level we can attest that client services and the provider and administrative infrastructure that support them often go hand-in-hand. In 2003-2007, due to administrative cuts and attempted efficiencies, the eligibility system became riddled with errors leading to mass disenrollment of children from Medicaid and CHIP. In 2017, cuts to ECI provider rates led to massive provider closures at the community-level, creating serious gaps in services for Texas children with developmental delays. In general, efforts to contain costs have led to severe underpayment of critical healthcare service providers such as ECI providers, mental health professionals and home health workers who support seniors and Texans with disabilities.

We write today to ask that this committee pause any new efforts to cut per-enrollee spending. Texas Medicaid serves our most vulnerable citizens, many of whom are at heightened risk for COVID-related illness and complications. This moment in time calls for our state to shift efforts to ensure that as many Texans as possible have access to the healthcare services they need. This includes ensuring that the Medicaid provider and administrative infrastructure is functioning effectively so that it can best serve vulnerable Texans.

Interim Charge #2: 1115 Healthcare Transformation and Quality Improvement Program Waiver

Over the last seven years, the 1115 waiver has helped support the Texas healthcare safety net by reimbursing state hospitals for services provided to uninsured Texans and funding local initiatives to improve healthcare quality, especially for people without insurance. However, waiver funds will fully phase out by 2021 with no expectation for renewal under any federal administration. At that time, state hospitals will be left without an equivalent source of funding to care for the uninsured. Many will have to cut services and others may even have to close their doors, like so many rural hospitals have already done. The needs of thousands of Texans that were served by 1115 waiver DSRIP projects will be left unmet while in the middle of a continuing public health emergency.

Beyond the population directly served by waiver projects, Texas has the highest rate and number of uninsured people in the country. Nearly one in five Texans is uninsured, this includes one in every four women of child-bearing age, one in every three non-elderly adults, and more than one in every ten children. Since the COVID-19 pandemic began 695,000 additional Texans have been added to the ranks of the uninsured.

We strongly urge the committee to expand Medicaid as a way to provide immense financial relief for patients, providers, and the state government. Medicaid expansion would provide healthcare access to 2.2 million Texans, many of which are struggling to make ends meet amidst a pandemic and strained healthcare system. Because the federal government covers 90% of costs, Medicaid expansion would more than replace the 1115 Medicaid Transformation Waiver funds and bring an estimated $10 billion per year in federal funding home to Texas. Many states that have expanded Medicaid have experienced net savings in their state budgets. A new report sponsored by the Episcopal Health Foundation also found that expanding Medicaid in Texas would have a net positive impact on the state budget whether it was funded with state GR or outside the state budget.

Interim Charge #3 - Hospital Finance Methods

One of the best actions this legislature could take to support hospitals across Texas, especially those in rural parts of the state, is to reduce the number of uninsured Texans. Texas is now one of only 12 states that does not have a coverage option for low-wage workers - many of which are serving as Texas's essential workforce during the pandemic. This has resulted in sky-high uninsured rates in our state and, nationally, the worst uninsured rate for nearly every population.

- 18.4% of all Texans lack healthcare coverage
- 29% of all non-elderly adults lack coverage
- 12.4% of all children are uninsured
- 1:4 women of child-bearing age lack health coverage
- 2x the national average for uninsured infants and toddlers

Texas' high uninsured rate translates to a higher incidence of costly preventable and chronic conditions, and higher uncompensated care costs for hospitals. While all hospitals have felt the strain of serving a growing number of Texans who lack a payment source, none have felt it as heavily as rural hospitals. Texas has by far the highest rate and number of rural hospitals closures in the country; high rates of uninsured patients is a primary driver. The expiration of the 1115 Transformation waiver in 2021 is expected to make this issue worse since those funds have provided a buffer to hospitals' uncompensated cost burden for the last seven years.

The financial impact of Texas's high uninsured rate is such a significant factor to hospital financing that Texas urban and rural hospitals as well as counties who have had to bear the brunt of the uncompensated care cost have called on the Texas Legislature to accept Medicaid expansion dollars in order to provide low-wage Texans access to healthcare coverage. Medicaid expansion or a similar solution, would bring an estimated 10 billion dollars a year to Texas, alleviate the pressure on local taxpayers, and provide the necessary infrastructure to tackle other healthcare cost drivers such as ER utilization rates and the incidence of chronic illness. Additionally, a recent study shows that Medicaid expansion would have a net positive impact on the state budget.

Medicaid expansion would provide the following specific benefits to hospitals:

1. reduce by a large measure the Uncompensated Care burden on Texas hospitals,
2. replace much of urban counties' programs for the uninsured funded with 100% local property taxes with 90% federal match,
3. allow Texas to finance the non-federal share of Medicaid with sources that are approved under federal law and guidance; and

4. allow Texas to rebalance Medicaid rates to cover provider costs, reach or approach Medicare parity, and eliminate the current non-transparent system of supplemental payments for care providers.

In addition to Medicaid expansion, Texas could reduce our child uninsured rate by:

1. Ensuring 12 months of continuous coverage for children in Medicaid, just like we do for higher income children in CHIP. Monthly eligibility checks mid-year have proven to be error prone and are erroneously kicking 50,000 children a year off their healthcare coverage.
2. Providing reliable information through HHSC to Texas families about the public charge rule to help ensure families are not disenrolling their children out of a falsely perceived fear that it could cause problems in a parent or family member's immigration process.
3. Increasing outreach funding primarily through the restoration of grants to community-based organizations.
4. Helping link newly unemployed uninsured Texans to Medicaid, CHIP, and the ACA Marketplace through innovative partnership with the Texas Workforce Commission, schools, food banks and other community points of contact.

Interim Charge #5: Early Childhood Intervention

Consistent coverage for children, especially under the age of three, is incredibly important for their physical and mental development. Unfortunately, at 12.7% Texas leads the nation in the number and rate of uninsured children including a higher-than-the-national-average uninsured rate for every ethnic group in Texas – White, Black, Hispanic, Native American and Asian.

We recommend the state implement these measures to lower the abysmally high child uninsured rate in Texas:

1. Stop state cuts to programs that enroll Texans in Medicaid for Pregnant Women, Children's Medicaid, CHIP, and other programs.
2. Improve outreach to families regarding children's health insurance options.
3. For children enrolled in Medicaid, allow them to maintain their coverage continuously for 12 months rather than checking eligibility mid-year -- which often result in children mistakenly getting kicked off.
4. For moms, extend Medicaid coverage to 12 months instead of 2 months after childbirth to reduce maternal mortality and morbidity rates -- which are already extremely high in Texas.
5. Expand Medicaid – research shows that when parents have healthcare coverage children are more likely to be enrolled in coverage and access needed care. Children are also better off overall when parent's financial, physical and mental needs are addressed.

Response to Request for Information
Appropriations Committee II
Texas House of Representatives

children at Risk
Speaking Out + Driving Change for Children

Interim Charge #5: Examine state's investment in early childhood education

- **Examine state investment in the health and brain development of babies and toddlers, including Early Childhood Intervention and other early childhood programs for children in the first three years.**
- **Evaluate opportunities to boost child outcomes and achieve longer-term savings.**

Background on Early Childhood Funding in Texas

In Texas, Early Childhood Education (ECE) funding is complex and funded in multiple federal streams. There are nine categories of early childhood funding that are allocated from the U.S. Department of Health and Human Services, United States Department of Agriculture (USDA), or the U.S. Department of Education.[1] Child Care Services is funded through the Office of child Care under Health and Human Services and focuses on providing subsidized child care for children from low-income families.

The Texas Workforce Commission (TWC) is the lead agency distributing the Child Care Development Block Grant (CCDBG) funding to the 28 Local Workforce Development Boards (LWDBs). Child care subsidies are the largest expenditure in TWC's budget – more than half a billion dollars in federal dollars via CCDGB funds per year, making it nearly 50% of the agency's budget.[2] In 2018, Texas received a 45% increase in child care funding. This amounted to roughly an additional $230 million per year in additional funding. During COVID-19, Congress distributed an additional $371,663,374 in supplemental CCDBG funding through the Coronavirus Aid, Relief, and the Economic Security (CARES) Act for the state of Texas.[3]

Increasing Access to Quality Child Care

Exposure to high-quality early ECE is the foundation to future academic success, especially for children from low-income backgrounds.[4] In the early stages of development, a child's brain is malleable and the elasticity of how the brain develops in these early years makes early engagement a strategy for success. This is especially true for children living in poverty who have the socio-economic odds stacked against them. For many of these children, ECE can buffer the negative effects associated with poverty and later academic achievement.

In Texas, there are more than 2 million children under the age of 5, half of whom are living in low-income households.[5] Roughly 1-in-10 children (0-5) in Texas, live in a child care desert. Prior to COVID-19, Texas was on a path to quality and made deliberate efforts to increase access to subsidized child care as an effort to provide affordable early educational supports for children from low-income families. The 2018 CCDBG funding increased the total children served in 2017 from roughly 100,000 to more than 130,000 – only 10% of eligible children.[6]

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However, before COVID-19, TWC reached only a fraction of low-income children and the child care providers who serve them. There were roughly 17,000 child care providers (center and home child care) in Texas, but only 46% of providers participate in the TWC subsidy program.[7] To make matters worse, only 22% of subsidy providers choose to participate in TRS. TRS is only open to child care providers who receive federal money from TWC. Participating providers can be quality certified at three levels: 2-, 3-, and 4-Star by meeting progressively rigorous benchmarks.

Across the state, only 1,658 (9.7%) of all child care providers are enrolled in the TRS system – estimated to serve roughly 56,000 children daily. The lack of participation of all providers in the TWC subsidy system - and specifically the lack of quality TRS subsidy providers - significantly limits the number of quality rated subsidy providers that low-income families can choose from.

Access to child care does not equate access to quality child care. Many providers across Texas struggle to acquire the appropriate staff and financial resources needed to offer high-quality care for infants and toddlers, which limits the availability of affordable and high-quality slots for infants and toddlers. As the state works to increase access, we must also work to increase the quality of these child care programs, especially those who are serving low-income children through the subsidy program. One systematic way to understand the quality of ECE prior to kindergarten is through Texas Rising Star (TRS), the state's voluntary Quality Rating and Improvement System.

Requiring subsidy providers to participate in Texas Rising Star will create accountability of government dollars, while simultaneously prioritizing quality.

Recommendation: Mandate participation of subsidy providers in TRS and offer training and technical assistance to providers.

Specific Policy Recommendation #1: Mandate Participation of Subsidy Providers in TRS with a Clear Timeline for Phase-In of the Requirements and Supports Needed.

To insure children from low-income families in publicly funded programs are getting the quality supports that benefit them, mandating subsidy providers to become TRS-certified will create transparency and accountability of government dollars while simultaneous prioritizing quality. Exposure to high-quality child care during the most malleable time in a child's brain can buffer the negative associations between poverty and later academic achievement by promoting growth across several developmental domains. ECE is increasingly seen as a promising mechanism for promoting positive literacy, numeracy, and socio-emotional and cognitive skills.[8] Additionally, children participating in ECE prior to kindergarten, on average, have higher graduation rates, lower enrollment in special education programs, and lower rates of behavioral issues later in life.[9] Vast amount of research supporting the positive effects of high-quality ECE is further

evidence that access to high-quality ECE prior to kindergarten is essential for our most vulnerable populations.

Requiring participation of subsidy providers will significantly increase the number of children accessing quality rated ECE. The current voluntary approach to TRS is not meeting the needs of children and families. CHILDREN AT RISK recommends a phase-in approach for the subsidy providers currently not participating in TRS. This will ensure that support systems are in place by TWC to assist providers and will assist providers in a smooth transition.

Investing in the Reimbursement Rates of Subsidy Providers

In Texas, providers are reimbursed according to their TRS quality rating. Providers without a TRS rating are reimbursed at what is known as the "base rate". Historically, reimbursement rates have been lower than what a parent outside the subsidy program would pay. Low reimbursement rates create barriers for families receiving subsidy because their child care options are limited by the reimbursement rates providers receive. Additionally, providers may not want to participate in the subsidy program due to the low rates, or low reimbursement rates may limit the number of subsidized children they can enroll.

TWC and Governor Greg Abbott recognized that focusing on quality early care and education provides a promising path forward for both our children's education and economic success as well as our state's economic competitiveness. The utilization of the 2018 CCDBG dollars accelerated this work by investing in initiatives such as increasing reimbursement rates for subsidy providers. TRS 4-Star provider's maximum reimbursement rate now equals the 75th percentile of the 2019 Market Rate Survey. TRS 3-Star providers moved to the 90% of 4-Star and TRS 2-Star providers increased to the 90% of the 3-Star rate. Moreover, during COVID-19, TWC allocated $153.8 million of the CARES Act to provide enhanced reimbursement rates through December 2020 to help providers that provided subsidized care with increased costs.[10]

Child care educators are one of the most important factors contributing to quality ECE. Higher reimbursement rates would allow providers to improve teacher compensation. Current child care educator salaries, especially those in programs accepting subsidy payments, do not reflect the complexity of their work. Low wage jobs often result in high turnover, which negatively impacts program quality. Further investment in teachers reduces turnover for child care providers and lead to quality teacher-child interactions.

Increasing Beyond the Published Private Rate

The changes to the TRS reimbursement rates provide evidence that Texas has chosen to prioritize and invest in quality ECE by encouraging more providers to become TRS-certified. However, the current reimbursement rates are still a fraction of what it takes to provide quality care to infants and toddlers. For instance, for infants in the United States, the average cost is $1,230 per month or $15,000 per year.[11] TRS 4-Star providers receive a $23.04 daily rate or $8,3330 per year. Low reimbursement rates make it difficult for providers to accept additional children receiving subsidy assistance.

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CHILDREN AT RISK interviewed many LWDBs and found that many providers artificially deflate their prices to better meet families' needs; therefore, it is possible these lowered prices do not accurately reflect the true costs associated with providing quality care. The Administration for Children and Families (ACF) say that state's may reimburse providers above their published prices to support quality if the local market conditions do not support the provision of quality services.

Specific Policy Recommendation #2: Increase Reimbursement Rates Above Provider Published Rates.

The federal government specifically allows state agencies to support quality by reimbursing at higher rates than providers' published private prices. CHILDREN AT RISK recommends TWC to amend its rule prohibiting this practice. Increasing the reimbursement rates would allow more providers to benefit from recent reimbursement rate increases, expand access to high-quality child care, and encourage more child care providers to become TRS 4-certified.

CHILDREN AT RISK recently released a new report that focuses on increasing access to quality affordable child care before and during a crisis. To view the report, click here.

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Response to Request for Information - House Appropriations Article II SubCommittee - Charge #5

September 30, 2020

Early Childhood Intervention (ECI) has proven to be an effective way of supporting Texas infants and toddlers with disabilities and developmental delays. However, the current program is hampered by a reduction in state funding — measured in terms of dollars per each enrolled child — compared to past years. While the increased appropriation to ECI during the 2019 legislative session was helpful, it fell far short of restoring ECI funding per enrolled child. This is one of the key reasons some ECI contractors have dropped out of the program in the last few years.

In the following pages, we provide additional information about ECI in Texas and recommendations for steps that the Legislature can take, including addressing the funding shortfall in ECI.

Early life experiences matter.

The earliest months and years of a child's life are a time of rapid physical, social, and emotional development. A baby's brain forms more than one million new neural connections every second. During this unparalleled time of development, the early experiences and relationships a child has with parents and caregivers influences how they master new skills like walking, language, cognitive skills, and social interactions. These experiences provide a foundation for future positive health outcomes and success in school and adulthood.[1]

Early Childhood Intervention (ECI) is an effective program that promotes early brain development.

ECI is an effective federal-state program that contracts with community organizations, such as Easterseals and Any Baby Can, to provide life-changing therapies and services to children under age three with autism, speech delays, Down syndrome, and other disabilities and developmental delays. By serving children during the critical first three years of life, a time of rapid brain development, ECI is highly effective in helping children learn to walk, communicate with their families, develop positive relationships, and gain the skills needed to be ready to start school, or meet other goals.[2] Additionally, children with developmental delays who receive ECI services are less likely to need special education by the time they reach kindergarten.[3]

ECI provides an array of family-centered, home-based and virtual services using a coaching model, in which ECI providers coach parents on how to interact with their child in ways that support the child's development. While many programs that serve young children were forced to close during the pandemic, ECI's coaching model allowed ECI providers to pivot quickly to telehealth, providing a lifeline for families. Staff at the state's Health and Human Services Commission (HHSC) have continued to effectively manage the ECI program through these challenges.

But ECI providers are under financial strain and too few Texas kids are benefitting from ECI.

Over the last decade, state leaders cut ECI funding, cut Medicaid reimbursement rates for therapy providers, and reduced eligibility. Amid this financial pressure, multiple programs made the difficult decision to close. In 2019, the Legislature provided a $1.5 million supplemental increase that helped selected ECI contractors and a $31 million boost for FY 2020 and FY 2021, for a total appropriation of $348 million in federal and state funds for the current biennium, including $7 million for Respite and Quality Assurance.[4] The funding provided by the Legislature for FY 2020 and FY 2021 equates to $433 per month for each enrolled child, 10 percent lower than the funding levels from FY 2012 to FY 2015. During that four-year period, per-child monthly funding ranged from $484 to $479, even after taking into account the funding reductions by the Legislature in 2011. **Current funding per-child is approximately the same as FY 2016 and FY 2017, when six ECI programs ended their ECI contracts with the state due largely to funding challenges.**[5] [6] In a survey of ECI contractors conducted by HHSC prior to COVID-19, two-thirds (20 respondents) said the FY2020 increase could fill some, but not all, of the anticipated financial deficits.[7]

Texas serves a significantly lower percentage of young kids through ECI compared to other states. In 2018, Texas served 2.34 percent of children under age three, compared to the national average of 3.74

percent, ranking the state 46th in the nation. Amid a growing population of Texans under age three, the state's ECI enrollment has increased each of the past several years, reaching nearly 60,600 children in 2019.

The racial breakdown of kids enrolled in ECI does not reflect the Texas population. In 2018, Black children represented only 8 percent of the children enrolled in ECI services, but they were 12 percent of children under age three in Texas. In that same year, White and Hispanic children were overrepresented in ECI.[8] The problem is noticeably worse now than it was a decade ago. In 2009, 12 percent of Texas kids enrolled in ECI were Black, compared to only 8.6 percent in 2019, a decline of 28 percent.[9] In a recent survey by Texans Care for Children, a third of ECI directors said that their programs were missing Black children due to limited Child Find efforts and resources.

More eligible children would benefit from ECI if community organizations were more aware of the program and state leaders ensured kids have health insurance to attend check-ups. Child care providers, social service organizations and community members would benefit from learning about ECI and how to refer families to ECI when they are concerned that a child may have a delay or disability. More public awareness would help educate parents about the services and supports ECI provides and let them know that no referral is required. Medical providers have been the main source of referrals to ECI in recent years, but they can't play that critical role if children miss check-ups because they are uninsured. Unfortunately, Texas has the highest uninsured rate for kids, with 8.3 percent of children under three in Texas uninsured.[10] Texas conducts inaccurate mid-year eligibility reviews in Children's Medicaid causing eligible children to lose benefits, contributing to the rise in uninsured children. These checks are suspended due to COVID. By moving to 12 months continuous eligibility after the public health emergency, Texas can help kids keep their coverage, get referrals to needed services like ECI, and have ECI services covered by their Medicaid insurance.

There are steps the legislature and state agencies can take to support ECI programs in order to boost child outcomes and achieve longer-term savings for the state.

Legislative Solutions:

- Restore ECI funding to the 2013 funding level of $484 per child each month to give contractors the capacity to enroll and serve all eligible children in their communities. The funding should account for projected caseload growth amid the state's growing child population.
- Increase funding for Child Find to support community awareness and outreach efforts to ensure all eligible children are identified, screened, evaluated, and enrolled in ECI.
- Increase funding for health coverage outreach and enrollment to help children enroll in and access Medicaid and CHIP so more children can attend well child visits, get referrals to needed services like ECI, and have ECI services covered by their Medicaid insurance.

- Ensure state-regulated private health insurance plans cover and reimburse for critical ECI therapies and services, including Specialized Skills Training and Targeted Case Management (SST and TCM).[11] [12] When insurers fail to pay for these common and effective services, ECI providers are forced to tap public funds (their contract dollars from the state) or charge families, a potential financial barrier for many families.

Legislative or HHSC Solutions:

- Evaluate and address the causes of the disproportionate under enrollment of Black children in ECI with input from Black families as well as researchers, health leaders, early educators, and community organizations working with Black families.
- Connect infants and toddlers to health care by ending error-prone mid-year eligibility reviews in Children's Medicaid and establishing continuous 12-month coverage.
- Through a CHIP state plan amendment, add Specialized Skills Training (SST) and Targeted Case Management (TCM) as covered services in CHIP.

Legislative or TWC Solution:

- Improve partnerships between child care providers and ECI programs and educate child care providers to identify missed milestones and refer families to ECI.

Recent Media Articles

- https://www.expressnews.com/news/local/article/Early-childhood-intervention-experts-worry-the-15352654.php#photo-19575453
- https://spectrumlocalnews.com/tx/austin/news/2020/07/28/families-of-texas-children-with-special-needs-fear-crush-of-proposed-covid-19-budget-cuts--

Endnotes

1. Center on the Developing Child at Harvard University (2010) http://developingchild.harvard.edu/wpcontent/uploads/2010/05/Foundations-of-Lifelong-Health.pdf
2. The Value of ECI. Texas HHSC - ECI. (2017). Retrieved from: https://txpeds.org/sites/txpeds.org/files/documents/eci-value.pdf
3. National Early Intervention Longitudinal Study (NEILS) Special Education and Part C Programs National longitudinal research on Part C programs tracked children with a developmental delay and found 46% did not need special education by the time they reached kindergarten as a result of early intervention services. Texas was part of the sample in the NEILS.
4. T.X. Legis. Assemb. Reg. Sess. 2. (2019). General Appropriations Act for the 2020-21 Biennium. (Used for 2020 and 2021 data). https://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2020_2021.pdf
5. Several articles on ECI contractors leaving the program in 2016/2017 citing funding challenges as a main reason: https://www.texastribune.org/2017/04/12/texas-lose-brazos-valley-childrens-therapy-provider/
6. At the start of FY16 there were 49 contractors. The 6 contractors who left the program in FY 16 were: North Texas Rehabilitation, Andrews Center, Emergence Health Network, Hill Country MHDD, Easter Seals East TX, UT Medical

Branch Galveston. Since 2010 eighteen contractors have exited the program, often citing funding challenges, including repeated years of financial losses incurred in delivering ECI services.
7. Texas Health and Human Services Commission. (September 2020). Early Childhood Intervention Services Implementation Plan for Maximizing Funding Progress Report. As Required by 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission, Rider 98). https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/eci-implementation-plan-progress-reports-sept-2020.pdf
8. Texas Demographic Center and Texas Health & Human Services Commission. (June 2020). Dataset from Open Records Request made by Texans Care for Children.
9. Texas Health & Human Services Commission. (June 2020). Dataset from Open Records Request made by Texans Care for Children.
10. U.S. Census Bureau and Center for Children and Families
11. Early Childhood Intervention Services Implementation Plan on Maximizing Funding (March 2020) https://hhs.texas.gov/reports/2020/03/early-childhood-intervention-services-implementation-plan-maximizing-funding-progress-report. Twenty-seven states collect private insurance as a funding source for ECI.
12. Texans Care for Children email exchange with Early Childhood Technical Assistance Center - *12 states with state statutes requiring insurance coverage for early intervention services: CT, CO, DC, FL, IL, IN, KY, MA, MO, NH, RI & VA*

House Appropriations S/C on Article II Interim Charge #5

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9/30/2020

Response to Request for Information - House Appropriations Article II SubCommittee Charge #5

The Coalition of Texans with Disabilities (CTD) is the largest and oldest member-driven, cross-disability advocacy organization in Texas. We focus on governmental advocacy, public awareness activities, and professional disability consulting to achieve our mission of building a society where Texans with disabilities can live, work, learn, play, and participate in the communities of their choice.

Early Childhood Programs are a Smart Investment for Texas
Children experience rapid growth and development in the first three years of life. Their early experiences and interactions with caregivers during this critical time directly impact physical, emotional, and mental well-being, and are shown to determine outcomes later in life. **While the primary beneficiaries of high quality early childhood programs are children and families, state and local government, taxpayers, and society as a whole all benefit from this investment.** Access to high quality programs decreases the likelihood of: needing special education services later, grade retention, early parenthood, dropping out of school, unemployment, and incarceration. For decades, economists and researchers have been reporting that the earlier the investment, the greater the return in education, economic, health, and social outcomes.

Early Childhood Intervention (ECI): Early Childhood Intervention (ECI) is a highly effective home-based school readiness program for babies and toddlers who are 0-3 years old with a developmental delay, disability, or other medical condition.The specialized array of services provided to families includes pediatric therapy (speech, occupational, physical), nutritional services, specialized skills training, targeted case management, and respite services. ECI is so effective, that approximately 46% of children who have access to the program go on to not need more costly special education services in public schools. The state ECI program not only supports the development of children, but serves as one of our state's most targeted child abuse prevention strategies by providing much needed relief to parents providing around-the-clock care to children with complex needs. We urge lawmakers to:

- Prioritize funding in the state budget to increase the per child allotment, fund for anticipated caseload growth, and increase funding for Child Find to ensure all eligible children are identified, evaluated, and enrolled in ECI.
- Ensure that private health insurance plans cover and reimburse ECI therapies, Specialized Skills Training (SST) and Targeted Case Management (TCM).

Inclusive Child Care: Parents of children with disabilities face significant barriers to obtaining and maintaining high quality, reliable, inclusive child care; resulting in parents dropping out of the workforce, family isolation, turning to unregulated care, and a missed opportunity to connect with other programs

like ECI. In fact currently child care providers only account for 2 percent of referrals to ECI. Babies and toddlers are missing out on the safe, inclusive, early opportunities that they deserve. We urge legislators to support the following recommendations:

- Revise anti-discrimination language in the Human Resources Code to also prohibit discrimination by child-care facilities and registered family homes based on disability.
- Adopt Child Care Licensing (CCL) Minimum Standards pre-service and annual professional development requirements to include training on supporting children with developmental delays and disabilities; and supporting early childhood mental health
- Strengthen relationships between ECI and child care providers to improve referrals to critical early interventions for babies and toddlers with disabilities and developmental delays.

We appreciate the opportunity to provide comment and are happy to answer any additional questions you may have.

House Appropriations Subcommittee on Article II
Comments on Request for Information Charge #5
Sept. 30, 2020

Submitted on behalf of:
Texas Pediatric Society
Texas Medical Association
Texas Academy of Family Physicians

Chairwoman Davis and Committee members,

Thank you for the opportunity to provide written comments on the Charge No. 5 request for information:

> *Examine state investments in the health and brain development of babies and toddlers, including Early Childhood Intervention and other early childhood programs for children in the first three years. Evaluate opportunities to boost child outcomes and achieve longer-term savings today on the vital importance of the ECI program for some of Texas' most at-risk and vulnerable infants and toddlers.*

A Child's First 1,000 Days Are the Most Crucial

The brain science is clear – a child's brain grows and is shaped by his or her experiences more between conception and the beginning of the third postnatal year than at any other time in the child's life.[1] Neurological pathways are being formed at a rapid pace, building on one another to create an increasingly complex structure. If one or more pathways develops incompletely or not at all, it could result in physical, emotional, and psychological consequences. Prolonged childhood adversity, adverse childhood experiences, and social determinants of health – the environments where children live, learn, and play – have the potential to dramatically impede early brain development and lead to life-long negative health and social outcomes. Therefore, Texas must enact measures to ensure all families have access to programs that promote optimal brain development and lifelong success. Federal programs, such as the Women, Infants, and Children program, the Supplemental Nutrition Assistance Program, and the Child and Adult Care Food Program are part of the solution, ensuring eligible families have access to nutritious food. Other programs include maternal, infant, and early childhood home visiting programs such as Nurse Family Partnership, children's and maternity Medicaid, and the Early Childhood Intervention (ECI) program. State lawmakers have specific authority to invest in and make policy enhancements to the latter three programs:

- Children's and maternity Medicaid,
- Early Childhood Intervention,
- Home visiting programs housed at the Texas Department of Family and Protective Services.

Medicaid Is the Largest and Most Vital Early Childhood Program in the State

The largest early childhood program in the state is Texas Medicaid, providing access to health care and other services to more than 3.2 million children and maternity care to 180,000 women. Beyond providing health care coverage, the program also serves as a vital social institution because of its regular contact with low-income parents and children. Before a child's third birthday, families will have used Medicaid to see their pediatrician or family physician 12 or more times for preventive pediatric health care. Well-child visits ensure children receive vital immunizations to protect them from infectious diseases; screenings to monitor for developmental disabilities or delays; physical examinations to monitor growth; and anticipatory guidance to keep them safe where they live, learn, and play. These visits also serve as referral hubs to other vital early childhood programs such as ECI and home visiting. Unfortunately, recent preliminary data from the Centers for Medicare & Medicaid Services show that primary, preventive, and mental health services have decreased among children in the Medicaid program. While service delivery via telehealth for children has increased dramatically, it has not increased enough to offset this decline in services. Moreover, the technology is not appropriate or viable for some services, including vaccinations. Vaccination rates, childhood screenings, dental services, and outpatient mental health services have not returned to pre-COVID levels.

Because COVD-19 will be part of our lives for the foreseeable future, Texas should collaborate with physicians, community clinics, health plans, and other stakeholders to increase outreach and better educate Texas families about the importance and safety of in-person health, behavioral, and dental services. For example, skipping in-person developmental screens could result in delayed diagnosis and intervention. As noted above, young brains rapidly change so if a child misses a developmental milestone, early intervention can still correct it.

Contributing to the number of families skipping their children's important preventive care appointments is Texas' error-prone, periodic Medicaid eligibility review system, which results in many children cycling on and off coverage. These reviews result in around 4,100 children being disenrolled from Medicaid each month, though nine out of 10 are still eligible. Parents then must reapply. This process adds to the reasons why Texas continues to have the highest number and rate of uninsured children in the nation. One in five uninsured children *in the country* live in Texas. Children churning off Medicaid leads to higher costs per enrollee because physicians and health plans cannot consistently manage or coordinate a child's health care needs. Furthermore, it hurts quality-based value initiatives in Medicaid managed care designed to control costs.

Texas Medicaid also pays for more than 53% of Texas births, making it the largest health care payer for Texas women's perinatal care from conception to postpartum. This time is crucial for child development and the safety and well-being of the mother. Unfortunately, Texas Medicaid coverage ends 60 days after birth, creating an unstable dynamic for mother and baby during this crucial time. We must find a way to ensure coverage for postpartum women, a recommendation by the Texas Maternal Mortality and Morbidity Review Committee. Texas recently created Healthy Texas Women (HTW) Plus to provide enhanced coverage for postpartum women, focused on the illnesses and conditions most likely to contribute to maternal mortality or morbidity, such as treatment for postpartum depression. HTW Plus is a step in the right direction. However, we support Texas extending a full year of *comprehensive* Medicaid coverage as well as drawing down federal funding to find a coverage solution for more than 1.5 million low-income working Texans currently without access to affordable insurance. Furthermore, in states that expanded Medicaid expansion, the number of uninsured children also declined. When parents have coverage and seek medical care, they are more likely to ensure their children are covered as well.[2]

Recommendations:

- Increase funding for health coverage outreach and enrollment to help families enroll in and access Medicaid and the Children's Health Insurance Program.
- Eliminate midyear reviews in children's Medicaid and institute the nationwide best practice of 12 months' continuous coverage.
- Extend Medicaid coverage for new mothers to one year postpartum and find a coverage solution to ensure all low-income working Texans can gain access to affordable health care.

Continued Investment in ECI Is Crucial Even During Fiscal Hardships

ECI is a statewide program for families with children, birth to age three, with disabilities and/or developmental delays. For more than 30 years, ECI has supported more than 800,000 families to help their children reach their potential through targeted developmental services and parent counseling and training. What makes ECI different from other services is its focus on training parents and other caregivers, such as grandparents or child care facilities, on how best to help a child achieve specific goals and developmental milestones.

The benefits of early intervention services, like Texas' ECI program, are numerous for both child health outcomes and economic advantages to the family and society. A substantial amount of longitudinal research has demonstrated that access to early intervention for children results in marked improvement in verbal abilities, receptive language scores, and overall cognitive abilities, which can translate later in life to better school performance, graduation rates, and social and emotional skills need to succeed in life.

By intervening early, when a baby's cognitive and physical health are still being formed, we can reduce costs in other domains and interventions, such as school-age special education services, and improve a child's functional trajectory for life. Furthermore, early intervention services such as ECI are vital to more high-risk populations of children including those who come from environments of abuse and neglect, those with mental health issues, those from culturally diverse backgrounds, and children living in economically deprived environments.[3]

It is also important to note that Texas' ECI program, compared with the national average, has demonstrated that when children do receive service, the program is especially effective in producing results. On the three global health outcomes reported to the federal Office of Special Education Programs, Texas children significantly increased their rate of growth in the following key domains:

- Positive social-emotional skills including getting along with other children and relating to adults;
- Acquisition and use of knowledge and skills including reasoning, problem solving, and early literacy and math skills; and
- Use of appropriate behaviors to meet their needs including feeding, dressing, self-care, and following rules related to health and safety.[4]

Primary care pediatricians and family physicians have the pleasure of caring for children with a wide variety of behavioral and developmental needs. Most children experience normal behavioral issues, including the so-called "terrible twos." But a subset suffers from hearing or speech delays, swallowing or walking difficulties, developmental delays, or other physical or developmental challenges that may affect one or more areas, including cognition, motor skills, and language. Delays may be mild or more far-reaching and can stem from a variety of causes, including autism, Down syndrome, or spinal muscular atrophy.

Given what the science tells us about the importance of early intervention in restoring or mitigating the effects of developmental delays, physicians who care for children are thankful for the ECI program, which provides early identification of development delays and in-home services to children 0-3 years of age. In fact, physicians are federally required to refer a child with developmental delay or disability under the age of 3 within seven days of identification.[5] Texas physicians make up most of the referrals to ECI programs and as such depend on a robust network of contractors across the state to address a child's development needs and to practice in accordance with the law.

The Texas Legislature made a sizeable $31 million investment in the ECI program during the 2019 legislative session to ensure a robust network of community providers in all areas of the state. Without these providers, children will go without much-needed services during the most crucial time in their life. While this investment is most welcome, it still does not raise the per-child spending to 2013 levels, or $484 per child each month. Furthermore, more investment is needed to ensure all providers have adequate funding for Child Find services, which go into hard-to-reach communities to find families who need services. This is especially important because of a 2018 report[6] that found Black children made up a disproportionate share of decreased enrollment compared with Hispanic or White children. Finally, to ensure ECI providers remain financially stable, we need to ensure they have access to as many diverse and sustainable funding and billing sources as possible. While providers currently pull from more third-party sources compared with any other state, they still have a difficult time billing commercial insurance for unique ECI services such as specialized skills training (SST) or targeted case management (TCM). Currently, Medicaid pays for these services, but many commercial insurances regulated by the Texas Department of Insurance (TDI) do not. To save the state money from paying for these services directly, the state legislature could require all TDI-regulated health plans to pay for SST and TCM. A 2017 Legislative Budget Board staff report recommends this approach. [7]

Recommendations:

- Continue investment in Early Childhood Intervention services to ensure all children can access needed services.
- Provide specific funding for ECI Child Find services to alleviate racial disparities in enrollment.
- Require Texas Department of Insurance-regulated health plans to pay for specialized skills training and targeted case management to save funding in Article II appropriations.

COVID-19 and Implementation of the Family First Prevention Services Act (FFPSA) Create a Perfect Opportunity to Invest in Early Childhood Prevention and Early Intervention Services

The COVID-19 pandemic has wreaked havoc on families with young children. The combined stress of ubiquitous public health messaging, social distancing, and the closure of classrooms and child care is a recipe for overworked and isolated parents. Families under financial pressures due to job loss can lead to anger, confusion, and increases in substance use. Children can then be at higher risk for abuse and neglect. As a state, we must rededicate ourselves to ensure families have the resources and services they need to thrive during these tumultuous times.

The Texas Department of Family and Protective Services uses several evidence-based prevention service models to offer services to families that prevent child abuse and neglect, increase protective factors, promote safety and healthy relationships in the home, and promote resilience. Many programs such as Nurse-Family Partnership and Parents as Teachers are considered well-supported by the Title IV-E Prevention Services Clearinghouse and are eligible for matched reimbursement through the new funding structure created by the FFPSA. Continued investment in these programs from the Texas Legislature can

draw down even more federal funding and in turn reduce spending in the child welfare and health care systems.

Recommendations: Bolster funding for Texas Department of Family and Protective Services prevention and early intervention programming to draw down additional federal dollars through the Family First Prevention Services Act and help families struggling through the pandemic.

Thank you for the opportunity to provide comments on behalf of our organizations. For any questions or follow up, please reach out to Clayton Travis, director of advocacy and health policy with the Texas Pediatric Society, at clayton.travis@txpeds.org or (512) 370-1516.

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House Appropriations Article II on Interim Charge #5

Regarding Investments in Early Childhood Intervention

Comments by Susan Murphree

On Behalf of Disability Rights Texas

September 30, 2020

Thank you for seeking stakeholder input on the House Appropriations Article II Committee Interim Charge 5 regarding implementation of legislation and riders passed by the 86th Legislature regarding investments in Early Childhood Intervention. These comments are on behalf of Disability Rights Texas (DRTx), Texas' designated protection and advocacy agency for individuals with disabilities. I am Susan Murphree, Sr. Policy Specialist with Disability Rights Texas.

- Evaluate opportunities to boost child outcomes and achieve longer-term savings.
    - Provide early intervention services and appropriate Autism services, including ABA when necessary, in sufficient amount, scope and duration and at reasonable rates to ensure ECI and Autism services are available and effective.
    - Increase appropriate referrals that result in enrollment in the Early Childhood Intervention program.
    - Increase the population served by the ECI program. Texas serves a significantly lower percentage of young kids through ECI compared to other states. In 2018, Texas served 2.34 percent of children under age three, compared to the national average of 3.74 percent, ranking the state 46th in the nation.

- Continue the progress already made to ensure that children with disabilities grow up in families and family-based alternative settings, rather than in institutions and group homes, where each child can best benefit from a nurturing parental relationship and reach his or her maximum developmental potential.
    - Provide timely community based services, including Medicaid and Medicaid waivers to eligible individuals with disabilities 0 - 20 years of age.
    - Apply the Family Opportunity Act's family income limit of 300% Federal Poverty Level after income disregards to the Texas Medicaid Buy-In for Children program and improve outreach so that more families can contribute to the cost of their children's care.

Thank you again for the opportunity to provide feedback. For more information, please contact Susan Murphree at smurphree@drtx.org

TEXAS COUNCIL *for* DEVELOPMENTAL DISABILITIES

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House Committee on Appropriations
Subcommittee on Article II

Texas Council for Developmental Disabilities
Written Comments on Interim Charge 5
September 30, 2020

Interim Charge 5. Examine state investments in the health and brain development of babies and toddlers, including Early Childhood Intervention and other early childhood programs for children in the first three years. Evaluate opportunities to boost child outcomes and achieve longer-term savings.

My name is Lauren Gerken, and I am the Public Policy Analyst with the Texas Council for Developmental Disabilities (TCDD). TCDD is established by state and federal law and is governed by 27 Governor-appointed board members, 60 percent of whom are individuals with developmental disabilities (DD) or family members of individuals with disabilities. The Council's purpose in law is to encourage policy change so that people with disabilities have opportunities to be fully included in their communities and exercise control over their own lives.

Thank you for the opportunity to provide public comment on Interim Charge #5, related to Early Childhood Intervention (ECI) Services, a foundational component to the long-term success and independence of many people with disabilities. Laying the groundwork for inclusion, independence, and self-direction begin much earlier in an individual's life than some may think, and ECI helps with this by supporting babies in Texas, ages 0-3. TCDD appreciates the Subcommittee's commitment to evaluating ECI services, as demonstrated by this Interim Charge.

TCDD supports the position that babies and toddlers with developmental delays, or suspected developmental delays, and their families should have continuing access to therapies, case management, and other specialized support services to promote healthy growth and development.

Early Childhood Intervention Services in Texas
In Texas, ECI services are family-centered and provided in a child's natural environment – meaning environments where the child spends most of his or her time and where typically-developing children spend their time as well. This could be the child's home, a grocery store, or

the family's favorite restaurant. This service model benefits the child more than clinic-based service models because, from the beginning, the child is learning how to adapt to a community setting.

The budget for services has been and remains at the heart of ECI providers', recipients', and advocates' conversations. Between 2010 and 2019, the available funds per enrolled child dropped $91.40. This resulted in a loss in services for many Texans. Between 2010 and 2018, it was reported that 16 programs stopped offering ECI services[1].

TCDD commends the Subcommittee for voting to fully fund ECI services during the 86th legislative session. As you know, the final version of the budget increased the ECI appropriation by $12 million. However, ECI contractors were also required to serve 29% more children at a 5.6% lower average monthly cost per child[2]. According to the Texas Health and Human Services' ECI Consumer Profiles, over 60,000 babies and toddlers received comprehensive services in 2019, which is approximately 7,000 more children than in 2016[3]. As the population in Texas increases, more children are diagnosed with or are suspected of having developmental delays, and the state budget should strive to meet the needs of these babies and toddlers.

Long-Term Investment: The Successes of ECI

National data has strongly supported the assertion that early intervention (EI) services, such as Texas' ECI program, is a positive financial and social investment for individuals, families, and states. As detailed in a one-pager compiled by The National Early Childhood Technical Assistance Center (NECTAC), "46% of children who had received EI and been at risk of needing special education services did not need special education at kindergarten age." NECTAC also shared that "children with hearing loss who receive EI within the first year of life have been shown to have language development within the normal range at 5 years of age." [4]

While there is national data and testimony regarding EI benefits, Texas lacks state-specific data regarding the long-term outcomes of ECI. Areas of interest for such ECI data are communication and motor skills post-ECI, the use of special education services, and graduation rates. Data in the areas mentioned above would better inform state budget development and educate Texas on the positive investments that exist within ECI.

The Impact of COVID-19 on ECI in Texas

The services provided by ECI are considered crucial and time-sensitive, which makes the COVID-19 impact on ECI a pandemic recovery issue. According to data tracked by the ECI state office, delivered service hours from March 2020—when much of Texas shut down due to COVID-19—through May 2020 show a decrease of 30 percent overall compared to the same period last year. Unfortunately, those lost hours are not replaceable, and many of the toddlers who have aged out of ECI since March 2020 will need to rely on other services to support continuing growth and healthy development. However, there is the opportunity to support the babies and toddlers still eligible for services within ECI when the state reopens fully, and the most vulnerable population is safer when therapists visit their home.

Recommendations for Increasing Opportunities and Achieving Long-Term Cost Savings in ECI

- Maintain steady funding established in the 86th legislative session to prevent losses in service and to support service recovery following the Coronavirus outbreak.
- Conduct a Texas-specific study of ECI's long-term impact, which examines the utilization of special education services when a child transitions into public school. The study should include students from kindergarten to the state-established transition age of 14 years old.
- Require ECI programs to provide a comprehensive overview of Texas Medicaid Waivers to promote long-term success of children and adults who benefited from ECI, including:
    - How to apply for waivers and remain on the interest list
    - The wait-times on each interest list
    - The services each waiver provides

Thank you again for your time. Please do not hesitate to contact TCDD with any questions or if we can provide any additional assistance.

Lauren Gerken, M.A.
Public Policy Analyst
Texas Council for Developmental Disabilities

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Submitted by: Autism Society of Texas; Coalition of Texans with Disabilities

House Appropriations Sub-Committee on Article II - Health and Human Services

The Autism Society of Texas (AST) works to improve the quality of life for all Texans with autism by offering innovative, person-centered support to people impacted by autism and their families. Autism is a lifelong developmental disability that affects 1 in 54 Texans, as well as their parents, caregivers and friends. We offer assistance through a myriad of services and programs related to advocacy, recreation, education and support. We work in partnership with our community, seeking input from individuals with autism to advise our decision-making and offering comprehensive education and training so that communities may become more inclusive. In tandem with members of the Early Childhood Coalition, we are providing comments today on issues that specifically impact children with autism across Texas.

Interim Charge #5: Examine state investments in the health and brain development of babies and toddlers, including Early Childhood Intervention and other early childhood programs for children in the first three years. Evaluate opportunities to boost child outcomes and achieve longer-term savings.

Invest in Preventive Services including Early Childhood Intervention (ECI)

One health care financing strategy that is not utilized well enough in Texas is preventative services. Investing in services upfront to gain greater return in the future is not only fiscally responsible, but, in the case of health care, helps Texans live fuller, healthier lives. When it comes to young children with disabilities, no preventative program is more valuable than Early Childhood Intervention (ECI) services. ECI is crucial to children with autism. Though autism is not commonly diagnosed in children ages 0-3, ECI providers can identify delays in young children consistent with autism, and recommend referrals for further evaluation. The return on investment associated with ECI services is significant: according to documents published by the Texas Department of Rehabilitative Services, every dollar spent on ECI programs across the country sees an

average return between $2.50 to $17.07.[1] Additionally, through speech and occupational therapies ECI prepares children for school, reducing the need for costly special education services and providing social behavioral skills development that is invaluable to children with autism and their families.

Despite the proven positive developmental outcomes associated with ECI, Texas consistently underfunds ECI services both in per child spending and anticipated caseload growth. While the increased appropriation from the 86th Legislative Session was helpful, funding continues to be inadequate. Underfunding the program has forced many ECI providers across the state to close, making it increasingly difficult for children with developmental delays to receive these foundation-building services, especially in rural areas. It is imperative that Texas invest appropriate resources in ECI to ensure that as many Texas children as possible are set up for success.

Adopt standards to promote inclusive child care for children with disabilities

Parents of children with disabilities face significant barriers to obtaining and maintaining high quality, reliable, inclusive child care, something that is only exacerbated by the current pandemic. When families do not have quality care it can result in parents dropping out of the workforce, family isolation and turning to unregulated care. Quality child care also offers an opportunity to connect with prevention programs like ECI. However, child care providers only account for 2 percent of referrals to ECI, and babies and toddlers are missing out on the safe, inclusive, early opportunities that they deserve. **Alongside our partners at the Coalition for Texans with Disabilities (CTD), we urge legislators to support the following recommendations:**

- Revise anti-discrimination language in the Human Resources Code to also prohibit discrimination by child-care facilities and registered family homes based on disability.
- Adopt Child Care Licensing (CCL) Minimum Standards pre-service and annual professional development requirements to include training on supporting children with developmental delays and disabilities; and supporting early childhood mental health
- Strengthen relationships between ECI and child care providers to improve referrals to critical early interventions for babies and toddlers with disabilities and developmental delays.

[1] Department of Assistive and Rehabilitative Services. *The Value of ECI*. Available from: https://www.texaschildrenshealthplan.org/sites/default/files/pdf/The%20value%20of%20ECI_K.pdf

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AUTISM SOCIETY
Improving the Lives of All Affected by Autism
Texas

The Autism Society of Texas believes that the above recommendations will help Texans with autism live better and more meaningful lives. We appreciate the opportunity to provide this input.

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Date: September 30, 2020
To: Appropriations Committee - S/C on Article II
Re: Request for Information, Interim Charge #5

Chair Davis, Vice-Chair Sheffield, and members,

Thank you for the opportunity to submit a response to the sub-committee's Interim Charge #5, relating to state investments in the **health and brain development of babies and toddler**s and the evaluation of **opportunities to boost child outcomes and achieve longer-term savings.**

Neuroscience confirms what parents and teachers have known intuitively **that babies and toddlers' brains grow significantly during the first few years of life**. According to the Centers for Disease Control, "**how well a brain develops depends** on many factors in addition to genes, such as: proper nutrition starting in pregnancy, exposure to toxins or infections and the **child's experiences with other people and the world**."[1] A child's day-to-day experiences affect the **structural and functional development** of his or her **brain**, including his or her **intelligence and personality**.[2]

Seeing that the majority of Texas' babies and toddlers spend the majority of their awake hours in child care, these **child care experiences play a key role in their development** and in the setting of the foundation for their **future success**. This period of rapid development also offers the **greatest chance to mitigate the dramatic inequities** that are already present in the development of kindergarten children. By just 2 years of age, many toddlers living in poverty already show cognitive and behavioral delays. According to James Heckman, a Nobel Prize winning economist, "The **highest rate of return** in early childhood development comes from **investing as early as possible,** from birth through age five, in disadvantaged families. **Starting at age three or four is too little too late**, as it fails to recognize that skills beget skills in a complementary and dynamic way. Efforts should focus on the first years for the greatest efficiency and effectiveness."[3]

According to an article in the official journal of the American Academy of Pediatrics, "When early experiences are **consistent, developmentally sound, and emotionally supportive**, **children learn optimally** and **develop resilience for life**. To focus only on the education of children beginning with kindergarten is to ignore the science of early development and to deny the importance of early experiences.[4]

The COVID-19 pandemic has further **highlighted the necessity and fragility of the child care industry**. Although, clearly an essential infrastructure to enable parents to work, the system is under-funded and under-resourced.

Current policy and practice does not adequately invest in these years. Educators for this age group earn the lowest wages and need to meet the fewest requirements. The younger the child, the less teachers typically make. **Policies that ensure a trained and consistent infant and**

toddler teacher workforce will help to ensure high-quality early care and education for our youngest Texans.

Additionally, the following funding opportunities will boost outcomes for our youngest Texans:

- The expansion of full-day pre-k, child care centers have diminished enrollment of their preschoolers. Although this is an important and strategic component to maximize early learning funding, the State must **shift funding to sustain high quality infant and toddler child care**.

- Texas should also **use federal funds** from the Child Care and Development Block Grant, (CCDBG) along with funding from the CARES ACT and the GEER Fund **to incentivize and sustain high quality infant and toddler child care** and recognize the value of the teachers of our youngest children.

- Texas should once again **invest general revenue to fund Child Care Regulation** and **free up federal CCDBG funds to support high quality infant and toddler care.**

In addition to maximizing funding and in order to achieve long-term savings Texas should implement the following recommendations:

- Stabilize high quality child care programs by **creating stronger incentives and requirements** for **partnerships** between high quality community-based child care programs and school districts as well as providing child care programs **opportunities to apply for TEA pre-k funding.**

- **Collect and evaluate data on Texas' early learning workforce**, specifically including the infant-toddler workforce, and develop a **state-specific strategy** that includes ways to address compensation with a focus on equity, access to health benefits and business supports as well as professional development opportunities.

- Ensure that **reimbursement rates** set by TWC that are paid to subsidized provide **align with ratio requirements** set by Child Care Regulation. Currently, regardless if the requirement is 1 teacher to 15 children or 1 teacher to 22 children, the reimbursement is the same.

We believe that these efforts will improve both short- and long-term outcomes for our children and result in long-term savings, something I know we are all working toward.

[1] https://www.cdc.gov/ncbddd/childdevelopment/early-brain-development.html

1. [2] Institute of Medicine, Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education
. *From Neurons to Neighborhoods: The Science of Early Childhood Development.* Shonkoff JP, Phillips DA, eds. Washington, DC: National Academies Press; 2000

[3] https://heckmanequation.org/resource/invest-in-early-childhood-development-reduce-deficits-strengthen-the-economy/
[4] https://pediatrics.aappublications.org/content/144/2/e20191766

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House Appropriations - S/C on Article II
Interim Charge #5: Evaluate opportunities to boost child outcomes and achieve longer-term savings

The Children's Hospital Association of Texas (CHAT) represents eight free-standing, not-for-profit children's hospitals located throughout the state of Texas. CHAT's mission is to advance children's health and well-being by advocating for policies and funding that promote children's access to high-quality, comprehensive health care. CHAT appreciates the opportunity to provide information to the House Committee on Appropriations: Subcommittee on Article II.

The number of children under age 18 living in Texas exceeds the **total population of 38 U.S. states and territories,**[1] **and one of every 10 children in the country lives in Texas** Thus, the State has a unique opportunity to nationally lead in ensuring that children receive the best healthcare. Children's hospitals and their affiliated health systems are the natural expert centers to help drive this effort, which will include measurable outcomes that demonstrate children are receiving high-quality healthcare at lower cost.

Texas Pediatric Quality Improvement

Children's hospitals believe that the healthcare transformation in the Medicaid program that began under the Delivery System Reform Incentive Payment (DSRIP) program should continue as partnership with the Texas Health and Human Services Commission (HHSC) and children's hospitals to further evolve the learning, best-practices and improvements through application in targeted pediatric populations.
The background and rationale for the development of this approach is well-founded in the literature and current practice.

- There is precedence in the Texas Healthy Mothers and Babies Collaborative.
- This approach is consistent with current directed payment programs such as models for Quality Incentive Payment Program (QIPP) and Network Access Improvement Program (NAIP).
- This approach assures a more effective transition for pediatric patients from DSRIP to a more sustainable model for the delivery of services and achievement of outcomes and will focus primarily on the Medicaid pediatric population.

The request has three parts:

1. Target Populations

Pediatric Quality Improvement in Texas builds on current DSRIP patient populations and also expands the scope of transformation work to include more comprehensive patient populations. Pediatric Quality Improvement addresses three areas of work:

- child and adolescent behavioral health;
- children with medically complex conditions; and

[1] World Population Review, last accessed on 9/23/20.

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House Appropriations - S/C on Article II
Interim Charge #5: Evaluate opportunities to boost child outcomes and achieve longer-term savings

- transitions of care from pediatric providers to adult providers or adult models of care.

2. Multidisciplinary Pediatric Expert and Stakeholder Input

Many services and programs overlap both in scope and the patients they treat. As a result, quality improvement will work best synergistically and as a coordinated system of care. In order to effectively oversee pediatric quality improvement, input from a multidisciplinary group, made up of clinical experts, administrative leaders, and other appropriate representatives and stakeholders will be necessary. This group will have the varied stakeholder perspective to ensure the programs stay on track and that there are agreed-upon pediatric outcome measures.

3. Program Components, Metrics, and Data Management

The vision behind the proposal is to approach healthcare transformation from a population health perspective. The foundational premise is to align goals, measures, and incentives across the continuum of care to achieve improved outcomes for a given group of patients. Program components have been developed as part of the CHAT DSRIP Transition Proposal and previously submitted and reviewed with DSRIP team leaders at HHSC.

Progress cannot be measured without data. Pediatric quality improvement will require a data management strategy and infrastructure to effectively and efficiently provide information about the progress of the proposed programs and population health improvement. As data management systems can be costly, it is imperative to look first to what data is already available, including from Medicaid managed care organizations and the Health and Human Services Committee as well as what outcome measures exist. Additional data and measures would supplement where appropriate.

Telehealth and Telemedicine in Children's Hospitals

Children's hospitals were innovating in the area of telemedicine and telehealth before the pandemic and have expanded the use of these technologies in response to the pandemic. These changes have allowed children's hospitals to continue to provide needed care, decrease exposure between patients and hospitals staff, and preserve personal protective equipment (PPE) while it was scarce. Federal and state-level flexibilities in the Medicaid program and private insurance have contributed to the success of telehealth and telemedicine.

On behalf of our members, CHAT requests that the state:

- Make permanent the flexibilities for telehealth and telemedicine granted in response to COVID-19.
- Require reimbursement for telehealth and telemedicine services at the same rate as in-person services.
- Explore solutions for licensure reciprocity issues.

Request for Information – Response
September 30, 2020

TO: Texas House Appropriations – S/C on Article II
Appropriations@house.texas.gov

FROM: Lee Johnson, MPA
Deputy Director, Texas Council of Community Centers
Ljohnson@txcouncil.com
8140 N Mopac
Westpark Building 3, Ste. 240
Austin, Texas 78759

RE: Request for Information (RFI) Response for Interim Charge 5 – Due September 30th

> ***Interim Charge #5:*** *Examine state investments in the health and brain development of babies and toddlers, including Early Childhood Intervention and other early childhood programs for children in the first three years. Evaluate opportunities to boost child outcomes and achieve longer-term savings.*

Texas Council of Community Centers represents the 39 Community Mental Health and Intellectual Disability Centers (Centers) throughout Texas statutorily authorized to coordinate, provide, and manage community-based services, as alternatives for institutional care, for persons with intellectual and developmental disabilities, serious mental illness, and substance addictions.

Early Childhood Intervention (ECI) is an important state-federal program providing a variety of services and supports to infants and toddlers with disabilities and/or developmental delays, as well as their families. Of the 39 Community Centers in Texas, 22 provide ECI services. These services range from speech therapy to nutrition education, and psychiatric interventions to case management. They take place in the community, in the home, in offices, and via telehealth.

Decades of research has conclusively demonstrated that services beginning early in a child's life can have significant positive impacts in educational settings and even into adulthood. Cost-benefit analyses have consistently shown that evidence-based ECI programs more than pay for themselves in the long run, in the form of reduced costs in education and other state-funded programs. The ECI model also benefits families by increasing their understanding of their child's needs and how to respond to them, building self-reliance and decreasing the risk of abuse and neglect. Although last session saw an increase in state funding for ECI, it was insufficient to offset the many years of cuts to the program, leaving these vital services in jeopardy.

ECI prepares children for a healthy start in school, avoiding later costs.

The first years of a child's life are filled with monumental growth and change. This developmental plasticity gives early intervention its power – addressing a child's developmental challenges as soon as possible can lead to gains in abilities that may not be possible or may be far more challenging to achieve later in life. The ECI model capitalizes on this, helping babies and young children cultivate the skills needed to swallow, walk, and communicate, and to further develop abilities that will help them throughout their lives. Children who receive these services are less likely to need special education services when they reach school age, resulting in decreased systemic costs and increased educational attainment and participation in the workforce.

The ECI coaching model helps families gain self-reliance and decreases the risk of abuse and neglect.

ECI services are delivered based on a coaching model that helps parents learn how to address their children's needs. Trained professionals offer services in the home and community, using real-world challenges to teach parents how to respond. This supports the child's development throughout the time they are enrolled in ECI services and beyond. It also has allowed ECI providers to quickly adjust to changed conditions during the COVID-19 pandemic, offering coaching and instruction via telehealth without a loss of efficacy.

Parents across the state have commented positively on the provision of services through telehealth, noting that it often feels easier and more efficient to fit into their busy lives. Telehealth also offers an opportunity for providers to reach families in remote areas, extending the workforce and allowing more children to access specialized services. Further investment in broadband and other technology will help further develop this progress, though post-pandemic it will be important to continue centering the families, ensuring that they are able to make the choice to pursue services in person, via telehealth, or through a mix of service modalities.

In addition to teaching parents how to meet their children's needs, ECI serves as a targeted child abuse prevention program by training them to better respond to frustrations and giving them the tools they need to continue to support healthy development. The stressors of the pandemic make this aspect even more important, as many parents have lost jobs, healthcare, and family members, or are dealing with increased housing instability and decreased availability of childcare. Parental responses to these risk factors for abuse and neglect are mitigated with effective ECI services.

In a challenging budget climate, investments in ECI are fiscally responsible and necessary.

Despite significant investments made during the last legislative session, the state's per-child ECI budget remains lower than it was a decade ago. This makes continuing to provide these important services challenging, as evidenced by the many providers who have had to give up their ECI contracts in recent years. Current per-child funding levels are similar to those of FY 2017-17, during which time six ECI programs decided to end their state contracts due to insufficient funding. There is great concern that this exodus will continue, potentially leaving areas of the state with no access to services.

Even if other providers can be encouraged to expand their service areas, ECI's short window from birth to 36 months means that even a month of lost services can cause significant disruption and setbacks in a child's developmental trajectory. This could lead to increased needs related to special education services

in school as well as increased healthcare costs when issues are not addressed in a timely manner. Additionally, much of ECI's funding is federal, and based on the state's maintenance of effort. Decreasing the state's ECI investments could jeopardize this larger pool of federal funds, further destabilizing the program.

As the Texas population continues to grow, ECI funding must keep pace so that the developmental needs of babies and toddlers can be met, helping them learn, grow, and thrive. ECI services are proven practices that more than pay for themselves over the course of a child's life and pave the way for Texas children and families to achieve their full potential.

Texas House Appropriations Committee
Article II Subcommittee
appropriations@house.texas.gov

September 28, 2020

Dear Chair Davis,

Thank you for the opportunity to comment on the Request for Information for ***Charge #5*** on behalf of Nurse-Family Partnership (NFP).

Since 2006, NFP has partnered with Texas as a public health nursing intervention designed to improve outcomes for first-time, high risk pregnant women and their children – and has served 17,743 families across Texas over the last 14 years.

About Nurse-Family Partnership

Nurse-Family Partnership pairs nurses with first-time mothers who are low-income (usually Medicaid-eligible) from as early in pregnancy as possible until their babies are two years old to help moms set goals to improve their health, their children's health, and their families' economic self-sufficiency. Traditionally, nurses visit with the mothers one-on-one in their homes for an hour on average approximately every other week. During the home visits, highly skilled and specially trained public health nurses assess mothers' health and their children's health and screen for health, mental health, substance use, domestic violence, and developmental milestones. Nurses also refer mothers to healthcare providers, social services, education, and employment resources and help mothers identify supports among and their networks of family, friends, and the community to reach their hearts' desires. At each visit, nurses work with moms to set small achievable goals from one visit to the next to help moms and their babies thrive physically and mentally, finish their education and find work.

Some of the outcomes documented in our randomized controlled trials include

- 48% reduction in child abuse and neglect
- 56% reduction in ER visits for accidents and poisonings
- 50% reduction in language delays of child age 21 months
- 67% less behavioral/intellectual problems at age 6
- 79% reduction in preterm delivery for women who smoke
- 82% increase in months employed
- 61% fewer arrests of the mother
- 59% reduction in child arrests at age 15

Nurse-Family Partnership Leads the Way with Telehealth During COVID-19 Pandemic

As public health nurses, Nurse-Family Partnership home visitors are undeterred by challenging circumstances whether hurricanes or pandemics. The Nurse-Family Partnership model has effectively integrated telehealth and alternate visit schedules as part of implementation since 2017. Drawing upon our success after Hurricane Harvey where we reached hundreds of mothers to assess their needs and delivered basic needs to moms before disaster relief organizations in many cases, Nurse-Family Partnership jumped into action to keep serving clients during the COVID-19 pandemic.

Pregnant and new moms are craving the credible information and support that NFP nurses provide and moms of toddlers are clamoring for ideas on how to keep their little ones safe and healthy at this time. Even though our nurses can't visit with moms in their homes, they have continued to deliver services via telehealth and alternate visit schedules, including enrollment and pre-natal visits. The NFP National Service Office is providing enhanced guidance and tools for our nurses and agencies, particularly related to mental health, intimate partner violence (IPV), substance use disorder, among other assessments, services, and supports. Through telehealth, Nurse-Family Partnership in Texas had its highest point in time enrollment ever on March 31st with 3,354 mothers enrolled.

NFP even partnered with Verizon during the first months of the pandemic to initiate a program called Phones to Families. This program provided 380 smart phones to families across Texas who needed them to complete telehealth encounters.

Continued Investment

Now more than ever, we need continued investment in Nurse-Family Partnership. For over a decade, the Texas Legislature has recognized the benefits of Nurse-Family Partnership including its outcomes and the return on investment. Every $1 invested in Nurse-Family Partnership yields up to $5.70 in savings on government spending. Our nurses are an integral part of the public health landscape for mothers and children in Texas. There are an estimated 38,294 first time births to mothers who are receiving Medicaid across the state who could benefit from Nurse-Family Partnership services, but with limited resources, we currently only reach a fraction of these mothers. That number will only grow as more families fall into poverty due to the economic impact of COVID-19.

We fully recognize that Texas is struggling to fund all public services in the wake of the COVID-19 crisis. However, now is the time to continue to build the critical public health nursing infrastructure that our state needs to prepare, prevent, intervene, offer relief, and lead recovery efforts when crises like COVID-19 occur. Moreover, Texas continues to lead the nation with the highest rates of maternal morbidity and mortality and infant mortality that are even more stark when disaggregated by race, ethnicity, and rural communities. At a time when hospitals and health systems are pulling out of more communities in Texas, we need more public health access, not less.

> The Legislature should invest more heavily in public health programs like NFP than ever before so that we can provide quality access to care for mothers and babies covered by Medicaid across the state.

New and Expanded Federal Resources for Nurse-Family Partnership

Although Texas and other states across the country will face tough budgetary decisions due to the impact of COVID-19 on the economy, there are new and emerging federal resources that the state can draw down to expand Nurse-Family Partnership services.

Family First Prevention Services Act

The Family First Prevention Services Act was signed into law as part of the Bipartisan Budget Act on February 9, 2018. This act reforms the federal child welfare financing streams, Title IV-E and Title IV-B of the Social Security Act, to provide preventive services to families who are at risk of entering the child welfare system.

States can use Title IV-E funds to prevent the placement of children and youth into the foster care system through services that provide in-home parent skill-based programs, mental health services, and substance abuse prevention and treatment services. Title IV-E funds can be used in this capacity for 12 months for children who are candidates for foster care and for pregnant or parenting foster youth and may be renewed as needed. Eligible services must be included in state's plan and meet one of three thresholds: well-supported treatment, supported practice, or promising practice. Nurse-Family Partnership is a well-supported program (the highest possible ranking) as defined by the U.S. Department of Health & Human Services Title IV-E Prevention Services Clearinghouse[1].

On September 1, 2020, DFPS released its Family First Prevention Services Act Strategic Plan[2] and under **Option 2F**, DFPS states that the department can expand existing evidence-based home-visitation programs like NFP with FFPSA funds in Texas.

DFPS states:

> These programs are proven to increase parents' protective capacity therefore decreasing the likelihood of their child's entry into foster care. PEI could expand this type of prevention service to families with young children under the age of 6, which data shows this age group as a particularly vulnerable age group at risk of child maltreatment.

DFPS proposes using these program dollars to fund an expansion that would serve an estimated 620 additional families at a total cost of $5.2 million over FY22-23; this option is scalable.

[1] https://preventionservices.abtsites.com/program

[2] https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2020/2020-09-01-Family_First_Prevention_Services_Act_Strategic_Plan.pdf

CARES Act

The CARES Act requires that payments from the Coronavirus Relief Fund only be used to cover expenses that (1) are necessary expenditures incurred due to the public health emergency with respect to the Coronavirus Disease 2019 (COVID–19);(2) were not accounted for in the budget most recently approved as of March 27, 2020 (the date of enactment of the CARES Act) for the State or government; and (3) were incurred during the period that begins on March 1, 2020, and ends on December 30, 2020. States have asked Congress for flexibility with these funds. In some communities in Texas, Nurse-Family Partnership nurses were pulled temporarily from NFP duties to attend to COVID-19 activities such as screening, testing, triage, and public call centers. As the costs for those services will be covered through the CARES Act, there may be cost savings to DFPS that could be used to expand Nurse Family Partnership or for one-time expenses that build the capacity of the program.

Medicaid and the Healthy Texas Women Section 1115 Demonstration Waiver

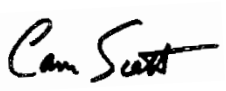
Texas could expand NFP services by leveraging federal Medicaid dollars for the implementation of NFP and coordinating referral processes from state agencies, MCOs, and other providers to deliver NFP to the most vulnerable moms and babies no matter where they live in Texas.

As part of Texas' current health care services structure, NFP is committed to supporting the strongest, most cost-effective approach to serving more Medicaid-eligible moms and their families at a critical time in their lives, also generating significant cost savings for the state by preventing unnecessary downstream Medicaid expenditures.

Legislative Appropriations Request

During the 2021 legislative session, we will respectfully request an increase of $4.4 million over the biennium to expand Nurse-Family Partnership to serve at least 400 additional families in Hardin, Jasper, Newton, Polk, and Tyler Counties in Deep East Texas and Collin and Denton Counties in North Texas. We would also like to request 1 FTE public health nurse position within the Department of Family and Protective services to provide clinical oversight for all 23 teams of Nurse-Family Partnership nurses in Texas and ensure that nurses are ready. These regions have some of the direst outcomes in the state. In order to improve the health and well being of all Texans, we must strategically invest in the areas of greatest need to promote health equity for all Texans.

Thank you,



Cam Scott
Senior Government Affairs Manager

TOTA
TEXAS OCCUPATIONAL THERAPY ASSOCIATION, INC.
1106 CLAYTON LANE, SUITE 516W • AUSTIN, TEXAS 78723 • PHONE 512-454-TOTA (8682)

To: The Honorable Sarah Davis, Chair; and Members
House Subcommittee on Article II
House Committee on Appropriations
appropriations@house.texas.gov

From: Texas Occupational Therapy Association
1106 Clayton Lane, Suite 516W
Austin, TX 78723

Date: September 30, 2020

Subject: Interim Charge #5

Dear Chairwoman Davis and Committee Members,

On behalf of the Texas Occupational Therapy Association (TOTA), thank you for the opportunity to provide comments to the House Subcommittee on Article II's Request for Information on *Interim Charge #5, Examine state investments in the health and brain development of babies and toddlers, including Early Childhood Intervention (ECI) and other early childhood programs for children in the first three years. Evaluate opportunities to boost child outcomes and achieve longer-term savings.* We appreciate the Subcommittee's work on ECI last session and the acknowledgment of the broader impact that investments in these policies have for Texas kids.

On a national level, the American Occupational Therapy Association (AOTA) reported that as many as 25 percent of students nationally have not been back to school since mid-March. Once virtual, parents often do not have the bandwidth (literally or figuratively), particularly for younger students and students with disabilities. When schools resume full-time and in-person, we could be facing a special education crisis. We know that ECI services for children ages 0-3 years old are the most effective and result in students having a lower reliance or eliminating altogether the need for special education, as well as other services later in life.

A recent survey conducted by AOTA in partnership with the American Physical Therapy Association (APTA) and the American Speech-Language-Hearing Association (ASHA) (attached) included almost 750 responses from ECI providers. The survey found that 42 percent of kids in Texas have not been receiving ECI services at all in the last six months as COVID-19 has disrupted much of normal life and normal access to health care. Again, knowing that ages 0-3 are such an important time for development, the impact of six months of not getting services ends up being much larger than just those six months.

One of our members recounted in 2011 when drastic cuts were made to public education and health and human services, the decreases in state funding to programs and the expectation that local programs would "pick up the slack" meant the end of many ECI programs across the state. We would like to see the committee monitor eligibility requirements for services, to ensure Texas babies and toddlers with measurable developmental delays will continue to have access to services.

While information about benefit cost analysis surrounding ECI programs indicate positive returns, these results are not always guaranteed. However, a review of 19 early childhood programs with benefit cost analysis demonstrated a benefit cost ratio range between $2 and $4 for every dollar invested (Cannon, et al, 2018). Budget allocations for the early childhood intervention program can contribute to improved outcomes for children and represent a sound investment in our future, and TOTA supports maintaining, or if at all possible, increasing funding for Texas' ECI program.

All children deserve a fair chance, and we must figure out ways to provide access to all children no matter their background. If we investigate reasons some children are left behind, then we can possibly find a solution to help children receive the services they may need for a brighter future.

Thank you again for the opportunity to comment and thank you for the Subcommittee's continued support and work on behalf of Texas occupational therapists and occupational therapy assistants.

Sincerely,

Judith Joseph, OTR -TOTA
Executive Director
Texas Occupational Therapy Association
Judith.Joseph@tota.org
512-454-8682

[redacted]

From: Rachel Gonzalez [redacted]
Sent: Wednesday, September 30, 2020 10:08 PM
To: Appropriations
Subject: ART2 Interim Charge 5
Attachments: APPROPRIATIONS SC.docx

Please see my attached comments.

Respectfully,

Rachel Meyer Gonzalez, MT-BC
Fellow, Academy of Neurologic Music Therapy
Owner/Director Therapeutic Rhythms
[redacted]

THERAPEUTIC Rhythms
NEUROLOGIC MUSIC THERAPY
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TEXAS HOUSE OF REPRESENTATIVES APPROPRIATIONS-S/C on
ARTICLE II REQUEST FOR INFORMATION
SUBMISSION 09/30/2020

I**NTERIM CHARGE**: Examine state investments in the health and brain development of babies and toddlers, including Early Childhood Intervention and other early childhood programs for children in the first three years. Evaluate opportunities to boost child outcomes and achieve longer-term savings.

BACKGROUND: The American Music Therapy Association defines music therapy as "the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program." In short…a music therapist uses music in ANY of its forms (recorded, live, songwriting) or ANY of its elements (rhythm, pitch, harmony) for NON musical outcomes.

Board-certified music therapists adhere to specific professional standards, including remaining within a designated scope of practice, following a code of ethics, and maintaining musical and clinical competencies. As neuroscience research has shown music to be processed in both hemispheres of the brain, music therapists address a variety of goals in cognitive, motor, speech/language, and behavioral/emotional areas.

The need for Early Intervention is more important than ever. It is now estimated by the CDC that as many as 1 in 6 children in the US has a developmental disability. These disabilities can be evident at birth or shortly thereafter and take multiple forms such as visual/hearing impairment, Down Syndrome, cerebral palsy, autism spectrum disorder, Tourette's Syndrome, epilepsy, cognitive impairment, attention deficit hyperactivity disorder, and many more.

Research has shown us time and time again that the earlier and more frequently a child gets quality services, by a qualified professional (or team of professionals), the LESS services a child will require across his/her lifespan.

I have a unique perspective on this. I was interim director and music therapy department head for a private clinic in California for 10 years that provided speech, occupational, physical and music therapy. For many years, the majority of our clients were ages 0-3 years old. These children would often see us for 2-3 services each week (ie, 2 hours of speech and 1 hour of

occupational therapy; or 1 hour of music therapy and 1 hour of speech) dependent on the particular needs of the client. What we noticed as clinicians, is if we had a child come to us at age 2 versus age 2 ½ with the same exact clinical picture, by the time the children aged out of Early Intervention at age 3, those that **started at age 2 averaged 30-50% less the amount of support required than those who started services at age 2 ½.** This of course would translate to a significant cost savings to the state beginning at age 3.

What we also noticed is while it was not uncommon for children to be referred and receive 2 hours of speech therapy and 1-2 hours of occupational therapy a week (3-4 hours a week), if children with the same clinical picture had 1 hour of music therapy along with 1 hour of speech and/or occupational therapy (2-3 hours a week), not only did the child often require less service, the outcomes were better than without music therapy. Music therapy added into the mix, proved to be one of the most cost-effective additions to children's programs as children would often require: a) less service over all per week, and 2) increase in progress towards goals.

ROLE OF MUSIC THERAPY IN EI

The question becomes, how could this be? While I wish I could turn back time and write a study to provide the data my theory (and that of my colleagues at the time) was and is that it is because of how music is processed neurologically and the role of evidence-based interventions that specifically address the needs of children in EI

- Motor Skills: interventions and treatments are able to specifically target walking, balance, coordination, hand usage, arm/hand strength and range of motion
- Communication: practice and preposition verbal skills, teach non-verbal language skills and means of communicating, specific sound/word production
- Sensory Stimulation: Improve processing of sensory stimuli for better attention, awareness, community integration
- Cognitive skills: Specific music therapy interventions addressing memory, attention, motor planning, learning pre-academic skills
- Socialization: Music therapy intervention can encourage developmentally appropriate play, help create family connections, and provide opportunities for interpersonal engagement and social interaction

Research has demonstrated that the brain that engages in music is changed by that music. And the change is not temporary, it is permanent. In the hands of a board-certified music therapist, music becomes a powerful therapeutic tool to change and transform lives.

My practice is a private community-based practice serving North-East Houston. Our clients are of all ages, abilities and diagnoses. However, state support is needed to increase access to care for families and children across the districts we serve. As a listed evidence-based practice of the National Clearinghouse on Autism Evidence and Practice, a related service under the Individuals with Disabilities Education Act, and an emerging intervention of The National Autism Center, music therapy should be invested in by the state within ECI programs that can help boost child health outcomes and promote brain development of infants, toddlers, and pre-school aged children.

CLOSING

Thank you for your service to this state and I look forward to continuing to support the health and brain development of all young children in our shared communities together.

Sincerely,

Rachel Meyer Gonzalez, MT-BC
Fellow, Academy of Neurologic Music Therapy
Owner/Clinical Director Therapeutic Rhythms

House District 127, Senate District 15

The Harrison Center for Music Therapy, LLC
4830 Wilson Road | PMB #189 | Humble, TX 77396
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TEXAS HOUSE OF REPRESENTATIVES
APPROPRIATIONS-S/C on ARTICLE II
REQUEST FOR INFORMATION SUBMISSION
09/28/2020

INTERIM CHARGE: Examine state investments in the health and brain development of babies and toddlers, including Early Childhood Intervention and other early childhood programs for children in the first three years. Evaluate opportunities to boost child outcomes and achieve longer-term savings.

BACKGROUND INFORMATION

The American Music Therapy Association defines music therapy as "the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program." Music therapy is an allied healthcare profession which purposefully uses elements of rhythm, melody, pitch, harmony, and lyrics to address non-musical goals. Board-certified music therapists adhere to specific professional standards, including remainig within a deisgnated scope of practice, following a code of ethics, and maintaining musical and clinical competencies. As neuroscience research has shown music to be processed in both hemispheres of the brain, music therapists address a variety of goals in cognitive, motor, speech/language, and behavioral/emotional areas. Interdisciplinary involvement allows music therapists to be catalysts for collaboration in an individual's treatment team. Music therapists form connections with patients, families, and other therapists to achieve a patient's personal and healthcare goals.

The CDC estimates that 1 in 6 children has a developmental disability. This includes a variety of conditions, such as autism spectrum disorder, intellectual disability, learning disability, attention deficit/hyperactivity disorder, hearing impairment, vision impairment, cerebral palsy, muscular dystrophy, Tourette Syndrome, and epilepsy. Conditions impact daily functioning and may result from genetic factors, birth complications, injury, or postnatal disease contraction. Early childhood intervention encompasses services for children of pre-school age who have been identified as having or being at risk for such developmental disabilities. These programs help children to meet developmental milestones, such as reaching, crawling, eating, communicating, playing with others, problem solving, and regulating emotions.

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BENEFITS OF MUSIC THERAPY IN ECI

While certain symptoms may persist throughout the lifespan for children with disabilities, early intervention is vital for learning and the development of compensation strategies. Music therapy can be a pivotal component of this intervention. As music activates numerous areas of the brain, individualized interventions developed and delivered by a board-certified music therapist may help an individual to form new cognitive pathways which work around impaired brain areas. Research touting the benefits of music intervention in childhood development has been published internationally in peer reviewed neurology, psychology, motor, speech/languauge, and music therapy academic journals. These benefits include provision of opportunities for:

- Multi-modal sensory stimulation
    - Music therapy intervention can incorporate varied sensory experiences, foster participation at different levels, and meet children at their current states.
- Motivating learning experiences
    - Music therapy intervention can encourage participation, improve attention, engage children in academic skill practice, and develop confidence/self-esteem.
- Relaxation/Calming
    - Music therapy intervention can promote body and emotional regulation, assist with pain management, and help develop stress coping strategies.
- Communication
    - Music therapy intervention can foster practicing of verbal skills, teach understanding of basic language structures, access nonverbal avenues of communicating, and promote vocalization or specific sound production.
- Socialization
    - Music therapy intervention can encourage developmentally appropriate play, help create family connections, and provide opportunities for interpersonal engagement and social interaction.
- Motor skill development
    - Music therapy intervention can promote functional movements address needs in reaching, grasping, use of both hands, finger isolation, balance, and coordination.

Research has shown that the brain which engages in music is changed by that engagement and that these changes may be generalized to other settings and maintained over time.

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We are an outpatient music therapy clinic serving Houston and its surrounding communities and districts. We treat patients of all ages, abilities, and diagnoses and have the privilege of providing music therapy intervention for patients in early childhood. However, state support is needed to increase access to care for families and children across the districts we serve. As a listed evidence-based practice of the National Clearinghouse on Autism Evidence and Practice, a related service under the Individuals with Disabilities Education Act, and an emerging intervention of The National Autism Center, music therapy should be invested in by the state within ECI programs that can help boost child health outcomes and promote brain development of infants, toddlers, and pre-school aged children.

COVID-19 ADDENDUM AND PUBLIC HEALTH CONSIDERATION

Children with neurologic differences often benefit from reliable routines and consistent intervention. When clinics and schools made the hard but necessary decision to close for the health of our communities during the pandemic, all of our young patients had that sense of reliability and consistency shaken. Remote services, delivered via teletherapy, have allowed us to continue our goal work in cognitive, motor, and speech-language domains.

We have been both thrilled and humbled by broader family involvement in teletherapy. Families throughout many districts have stepped up to provide physical and verbal support for children during music therapy sessions. Time and time again we have watched parents and guardians provide hand over hand assistance for instrument play targeting arm strengthening, add their voices to singing of patient preferred songs targeting consonant sound production, and participate in our sessions in countless other ways. This widespread involvement has broadened increased family engagement in treatment plans, energized the community about the benefits of teletherapy during this uncertain time and demonstrated the need for music therapy services within Medicaid and ECI programs. Cohesive family involvement in our nonmusical goal work would simply not have been possible without support for teletherapy services when needed during this pandemic.

Music therapy inclusion within ECI programs in Texas, both in person and teletherapy, may support instrumental growth and long term success for young children. As many schools and clinics now contemplate or are actively opening, many of our patients are not able to attend alongside their peers due to comorbid health conditions which compromise their immune systems. Continuation of teletherapy is the only way we can tell these patients, "I am still here for you". By supporting the provision of an ongoing teletherapy option, you are increasing access to care and sending your constituents this same message.

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CLOSING

Thank you for your service to this state and we look forward to continuing to support the health and brain development of all young children in our shared communities together.

Sincerely,

The Harrison Center for Music Therapy Team

Treating patients in all districts throughout Houston

Kate Harrison, MT-BC: Constituent of House District 142 and Senate District 6

Ingrid Moeller, MA, MT-BC: Constituent of House District 134 and Senate District 17

Whitney Morelli, MM-MT-BC: Constituent of House District 134 and Senate Distric 17